HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

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HOSPITAL ABSTRACTS

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HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 695, 697, 763

641. AMERICAN HOSPITAL ASSOCIATION. **Hospitals in the 1980's: nine views.** Chicago, American Hospital Association, 1977, vi, 234pp. $18.50

A series of nine papers commissioned for the Symposium on the American Hospital in the 1980s held at Airlie, Virginia, from 1-3 December 1976, is presented. The areas studied are the organization of the hospital resources, the changing scope of health care and the impact of a trend towards a greater public accountability. To each area there are presented the reactions of providers, researchers and the public. The final area covers the public policy issues facing hospitals. The issues identified by the papers and the symposium discussions are summarized and a select bibliography is provided after each paper.

642. LAFARGE, H. Hospitalisation publique et hospitalisation privée: une approche économique de leur appréciation. **[Public and private hospital care—an economic approach.]** *Revue d'Epidemiologie et de Santé Publique*, Paris, 1977, vol. 25, no. 4, pp. 275-296.

A LEGOS (Health Organizations Economics and Administration Laboratory) team from the University of Paris compared the activity of 16 hospital establishments: six general surgical, four maternity, and four specialized medical (cardiology and dialysis) units or clinics, half of which were in the public sector and the other half in the profit-making private sector. They sent questionnaires to the medical and nursing staff and to the patients and studied the patients' accounts. In 16 tables and three graphs they present the results of their comparative analyses of the medical and economic data: diagnosis, type of treatment, and accounts (key-letter classification of procedures carried out, length of stay, items invoiced, and total account). These show that the private sector concentrates on lucrative procedures and that its patients are admitted by appointment. The public hospital, on the other hand, treats the whole range of illnesses and 70 per cent of its patients are admitted as emergency cases. Economic considerations are therefore secondary in this sector.

643. SIMON, J.-M. Le rôle des hôpitaux universitaires dans l'agglomération de Paris et la région Île-de-France. **[The role of teaching hospitals around Paris and in the Île-de-France region.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 51-54.

The *Assistance Publique* (AP) is responsible for about one-third of all hospital beds in Paris and the Île de France. It has 44 hospitals of which 30 are university hospitals. New clinical specialties have been created or developed in the latter over the past few years and they use advanced techniques and equipment. As there has been an outward movement of population, the AP has built five acute 500-bed, one 200-bed and four medium-stay hospitals, providing nearly 3,000 beds, on the periphery of the city. In

future the AP intends to provide general medical and surgical services for the population in the immediate vicinity of its general hospitals, and highly specialized treatment for patients from a wider area (as many as 17 per cent from outside the region) in its university hospitals. It also foresees an expansion of the university hospitals' out-patient clinics, day hospitals, and rehabilitation centres. Also in: *Revue Hospitalière de France*, Paris, 1977, Nov., vol. 42, no. 305, pp. 849-854 and *Hôpital à Paris*, Paris, 1977, Nov./Dec., no. 42, pp. 531-535.

PLANNING, DESIGN AND CONSTRUCTION

644. PERLIN, M. S. **Managing institutional planning: health facilities and PL 93-641.** Germantown, Md., Aspen Systems Corporation, 1976, xiii, 149pp. $15.00

This book describes the planning structures, processes and methods that are being successfully adopted by health institutions in order to receive approval for the expansion of schemes or services in the United States. It begins with a description of the specific institutional planning requirements under the Health Planning Resource and Development Act. The remainder of the book focuses on the structure, analysis and methods of planning with examples of how a variety of health institutions carry out this management function. The history of hospital planning in the United States is outlined and possible future developments discussed.

645. SCARANO, J. **Construction management ensures flexibility in project delivery.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 99-100, 102, 104.

Hospital administrators are making increasing use of construction management for new projects. The construction manager works as the hospital's agent with the responsibility to manage project delivery from beginning to end. Some features of construction management are outlined and its advantages are discussed. The primary advantage is flexibility. At each point in a project, the client, with the backup of current reliable data and a full array of professionals, can re-assess the project and adjust it to his needs.

HOSPITAL DESIGN

See also Abstract No. 724

646. AMERICAN HOSPITAL ASSOCIATION. **A portfolio of architecture for health.** Chicago, Ill., American Hospital Association, 1977, vi, 160pp. $17.50

This portfolio was published to show the current state of the art of health facility design and construction in the United States. The contents are taken from the Architecture for Health exhibit of the 1976 annual convention of the American Hospital Association sponsored annually by the American Hospital Association together with the American Institute of Architects. There are 77 projects, including hospitals, long-term care institutions, health centres, diagnostic and treatment centres, medical offices, medical laboratories, staff housing, and medical research facilities. There are nearly 300 illustrations. The book has three indexes: by architectural firm; facilities; and subject.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract No. 724

647. HEYMANNS, H. A. Die Planung für den Neubau des Stadtspitals Dornbirn. **[Planning for the new building of the Dornbirn city hospital.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1977, Sept., vol. 18, no. 9, pp. 500-508.

Plans for the new building for the municipal hospital at Dornbirn (Vorarlberg) were finally approved in April 1977. It is to have 295 beds allocated as follows: medical, 85; surgical, 75; obstetrics and gynaecology, 50; paediatrics, 50; ear, nose and throat, eye diseases, urology, 35. The building is to be a seven-storey slab block, its two wings linked by a traffic core. There are two subground floors housing technical services, civil defence shelter, kitchens, laundry, stores and medical records. The ground floor houses administration, reception, out-patient and X-ray departments. On the first floor are the operating suite and other treatment areas. One wing of the second floor is allocated to technical services and the other to communal areas and cafeteria. The five ward floors each have two 33- to 37-bedded wards (except the top floor which has one ward and the hospital chapel). There are plans of all lower floors and a typical ward floor.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See also Abstract No. 795

648. NEW ZEALAND. DEPARTMENT OF HEALTH. HOSPITAL DESIGN AND EVALUATION UNIT. **Ward facilities for long-stay geriatric patients: part 3 of a study of planning requirements for geriatric patients by M. E. Penthy and M. MacKenzie** (Report No. 4) Wellington, Department of Health, Hospital Design and Evaluation Unit, 1976, [101]pp.

This is the third part of the second report by the Hospital Design and Evaluation Unit. Aspects considered include: general observations on the hospitals studied; conclusions; and design recommendations. A summary of the report is included together with drawings of bedroom dimensions, and three appendices covering key plans, background data and patient categories, and work flow diagrams for sluice activities.

WARDS AND PATIENTS' ROOMS

See also Abstract No. 652

649. HOET, T. Évolution dans la conception des chambres d'hôpitaux. **[Evolution in the conception of hospital rooms.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Nov., vol. 33, no. 386, pp. 63-66; summaries in English, German, Italian and Spanish, p. 66.

Today's hospital patients are no longer housed in enormous wards but in rooms which contain at the most six beds; each room has its own WC, and each patient his intercom. The bed is multi-purpose, adjustable, light, and manoeuvrable, with Fowler articulation and an adjustable headrest. It is designed to provide maximum comfort for

the patient and ease the nurse's work-load. The same is true of the furniture and the room itself; hygiene and convenience are paramount. The best rooms are well ventilated, sound-proofed, pleasant to look at and functional. The author recommends that industrialists should design their products with these factors in mind. There are three photographs of modern equipment.

ENGINEERING SERVICES

ELECTRICAL INSTALLATIONS AND EQUIPMENT

See Abstract No. 656

ARTIFICIAL LIGHTING

See Abstract No. 653

TRANSPORT IN GENERAL

See also Abstract Nos. 732-737, 775, 778

650. KAYE, V. **Six hundred square miles that add up to a heavy workload.** *Health and Social Service Journal*, London, 1977, Oct. 7, vol. 87, no. 4561, pp. 1402-1403.

Each day the London Ambulance Service receives 1,500 emergency calls from all over Greater London and carries out 9,000 non-urgent patient journeys. Between 300 and 400 applicants per year are accepted for a training course, either for full ambulance work or for non-urgent work. New equipment and methods are introduced in development courses. A map at the headquarters in Waterloo Road shows the availability of emergency service ambulances at London's 75 stations. It takes about eight minutes to get an ambulance to the spot and in the case of a major emergency, hospitals are alerted and a set procedure unfolds. The management of the ambulance service has been complicated by health service re-organization.

VENTILATION AND AIR-CONDITIONING

651. FANETTI, A. La protezione del circuito vapore. **[The protection of the steam heating system.]** *Tecnica Ospedaliera*, Roma, 1977, Oct., vol. 7, no. 10, pp. 50-54.

The hot water and steam system at the San Giuseppe Hospital in Milan showed signs of premature ageing: holes were found in the boiler pipes and the iron content in the condensate water was found to be of the order of 15 ppm. The author describes the chemical reactions which occur when iron comes into contact with water. In this particular instance the problem was solved by the installation of a CILLIT-MDP automatic system which adds monitored doses of CILLIT-HS conditioner to the water system. The article includes five illustrations.

652. LEGG, R. C. **The ventilation of hospital wards.** *Building Services Engineer*, London, 1977, Nov., vol. 45, no. 8, pp. A17-A19.

The recorded history of the ventilation of hospitals goes back over 200 years and is outlined in this article. During the latter half of the nineteenth century the standard wards of 30 beds were ventilated through windows on opposite sides. Circular wards with an integrated ventilation system were also advocated, but few were built. However, the use of mechanical ventilation systems increased and recommended ventilation rates have remained virtually unchanged for the last 100 years or so. Since about 1950 it has been the practice to build multi-room ward units, usually with mechanical ventilation systems, and in recent years, many designers have incorporated full air-conditioning to provide comfortable conditions throughout the year.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

See also Abstract No. 649

653. Nuovo testaletto per camere di degenza. **[New bed head fittings for hospital wards.]** *Tecnica Ospedaliera*, Roma, 1977, Oct., vol. 7, no. 10, pp. 62-64.

Seven photographs illustrate the features of the 'Hospital System', a new bedhead fitting made of anti-corrosive, anti-scintillation aluminium. The fitting includes a 65W fluorescent tube for general lighting, two 20W fluorescent tubes for medical examination of the patient, a blue night light, connections for medical gases, a telephone connection, an intercom, and two call buttons. The fitting is easy to clean and maintain.

HARDWARE, BEDPANS, URINE BOTTLES

654. BRITISH STANDARDS INSTITUTION. **Specification for hospital hollow-ware made of plastics material.** (BS 5452:1977) London, British Standards Institution, 1977, 8pp.

This British Standard specifies requirements for hospital hollow-ware made of plastics materials. Requirements for quality and finish are laid down to ensure that articles give a satisfactory performance for their stated use within the range of this specification. Aspects considered include: dimensions; materials; design; freedom from toxicity; finish and workmanship; impact resistance; effect of sterilization; resistance to handling under load; and marking. A table of dimensions of plastics hollow-ware and eight figures of plastics ware are included together with two appendices.

EQUIPMENT GENERALLY

See also Abstract No. 740

655. SOUTHERN CALIFORNIA. UNIVERSITY CENTER FOR HEALTH SERVICES RESEARCH. **Health technology: issues and activities.** Chicago, American Hospital Association, 1977, v, 154pp. $6.50

This book presents a preliminary discussion of the current status and future role of

health technology in the delivery of health care in the United States. The material was developed by the center for Health Service Research of the University of Southern California for the American Hospital Association. The book traces the involvement of federal legislative and regulatory activities in shaping the role of health care and offers guidance in evaluating many of the new technologies now being used. The two major forces considered responsible for advances in health care are the computer and outgrowths of space programme technology. Their impact is discussed together with the effect of government involvement. A review of Foundation Award activity and the United States project catalogue are included as appendices. Lists of references, a bibliography and further sources of information are also included.

MEDICAL EQUIPMENT

See also Abstract No. 655

656. HOENIG, S.A. and SCOTT, D. H. **Medical instrumentation and electrical safety: the view from the nursing station.** New York & London, Wiley, 1977, xii, 355pp. £8.20

The book describes how to make safe use of electrical equipment in operating rooms, hospital rooms and in intensive care, cardiac care, burn and kidney units. Aspects considered include: basic electricity; electrical safety; and medical instrumentation, together with coverage of the latest tests and equipment used in infra-red scanning, ultra-sonics, nuclear medicine, patient monitoring, and computer applications. A glossary of terms and information on examination questions, liability of the nurse, sources of information and further reading are included in four appendices.

ELECTRONIC EQUIPMENT

See Abstract No. 767

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract No. 749

RECRUITMENT

See Abstract Nos. 657, 665, 666, 674, 750

STAFF MANAGEMENT

See also Abstract No. 675

657. ROCHAIX, M. Le facteur travail dans le domaine santé: remarques préliminaires. **[The work factor in the health field: preliminary remarks.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Nov., vol. 33, no. 386, pp. 39-41.

In the past 20 years the number of staff employed in public hospitals in France has

risen from 60,000 to 500,000 and generally speaking the staff today are more highly qualified than in the past. However, in a period of rapid change, knowledge soon becomes obsolete and career structures are still too inflexible to allow effective redeployment. The authors suggest that the forecasting and planning of hospital staff requirements should be done on a national level and that steps should be taken to introduce multidisciplinary training and ensure greater flexibility in career structure. They believe that fundamental research should be carried out forthwith to ensure that the hospital work-force in the future will be adequate both in quantity and in quality.

658. MONACO, R. J. and SMITH, T. T. **How supervisors can put systems to work in day to day management.** *Hospital Topics*, Chicago, 1977, Sept./Oct., vol. 55, no. 5, pp. 34, 36-41.

Successful hospital organizations must be able to manage both the routine and the non-routine events, and computers can help with both these aspects of management. When linked to information systems, computers come to resemble the hierarchical and collateral structure of an organization. Different 'patterns' of communicating information are described, some representing routine, formal tasks and others, like the circle, representing the part of the organization where problems are solved. The computer can pick out problems which should be attended to at a higher managerial level. The organizational structure of a complete hospital, involving formal routines and collateral systems, is described by means of diagrams. Each unit may communicate with another through the central computer. Sub-systems and their units are also described, each provided with data processing equipment. Computers are enabling hospitals to provide a higher quality of health care by planned use of both formal and collateral systems.

STAFF TRAINING

See also Abstract Nos. 661, 666, 667, 676, 677

659. EGDAHL, R. H. and GERTMAN, P. M., editors. **Quality health care: the role of continuing medical education.** Germantown, Md., Aspen Systems Corporation, 1977, xxiii, 245pp. $19.00

This volume of 19 essays examining the link between medical education and quality health care in the United States arose out of a conference held by the Boston University Program on Public Policy for Quality Health Care in Boston, June 1976. The aim of the collection of essays was to provide a brief background to the variety of issues on continuing medical education and the quality of medical care. The papers are related to the five topic areas that the conference was expected to consider: current voluntary schemes in continuing medical education; mandatory or required systems of continuing medical education; evaluation of continuing medical education schemes; financial aspects and policy alternatives to mandatory schemes. Policy recommendations of the Boston University Health Policy Center on the relationship of continuing medical education to the quality of medical care are also included.

STAFF WELFARE

See Abstract Nos. 668, 678

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

660. SHORTELL, S. M. **Managerial models.** *Hospital Progress*, St. Louis, 1977, Oct., vol. 58, no. 10, pp. 64-69.

Four major forces will result in significant changes in health services administration in the United States in the 1980s: increased regulatory control; phased-in national health insurance; development of multi-unit systems; and continued growth of technology. These forces will have a significant effect on hospital governance, medical staff organization, administrative structure, use of manpower, and finance. Administrators will be required to combine their technical, political and visionary abilities into new ways of thinking about the management process. Specifically, the manager must emerge in the roles of evaluator and applied scientist. The roles will require the manager to: (i) be a rigorous evaluator of the organization's environment; (ii) become an applied epidemiologist in evaluating the efficiency of services delivered to a defined population; (iii) focus more on end results; (iv) think in terms of relationships; (v) think in multivariable terms and consider possible interaction effects; and (vi) think in larger system terms, considering the greater degree of interdependency among health care organizations.

661. LACASSIN, C. Le directeur de la formation à l'hôpital. **[The staff-training manager.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Dec., no. 387, pp. 60-64, 69; summaries in English, German, Italian and Spanish, pp. 64, 69.

The lot of the staff-training manager in a large hospital is not a happy one. His main role is to co-ordinate the activity of the many training schools for paramedical staff, to monitor teaching standards in co-operation with the regional health inspectorate, and to manage the training budget. In-service training is responsible for his major problems; in this area he must attempt to reconcile the views and wishes of management, trade unions, and individual members of staff, and he is often caught in the crossfire between these groups. He has to devise a training policy, create a favourable climate, and make proposals for action. From his experience the author believes that in-service training should be given within the hospital itself, since the cost of sending staff elsewhere is very high, and training should concentrate to begin with on the fields of work organization and human relations.

MEDICAL STAFF

See also Abstract Nos. 659, 702, 739, 750

662. CHERKIN, D. and LAWRENCE, D. **An evaluation of the American Medical Association's Physician Masterfile as a data source—one state's experience.** *Medical Care*, Philadelphia, 1977, Sept., vol. 15, no. 9, pp. 767-779.

The American Medical Association's (AMA) Physician Masterfile is the most complete and comprehensive source of physician data in the United States and provides

the only continuing system of national physician data. In this evaluation of the system, the completeness and reliability of the data were assessed for physicians licensed and living in Washington State. Comparison of the AMA data with state licensure data indicated excellent agreement, with only a small proportion of licensed physicians 'missing' from the Masterfile. Their absence was due largely to differences in the manner in which the two systems updated their files. The reliability of the AMA data was checked by comparing it with similar, independently gathered survey data on birth date, birthplace, medical school, type of practice, specialty, board certifications, and employer. In general, despite some minor deficiencies, the AMA data were shown to be highly reliable.

663. VERBY, J. E. **The Minnesota rural physician redistribution plan, 1971 to 1976.** *Journal of the American Medical Association*, Chicago, 1977, Aug. 29, vol. 238, no. 9, pp. 960-964.

The Rural Physician Associate Program was developed by the University of Minnesota Medical School in an attempt to meet the demands for improvement in the distribution of primary physicians to rural area. The programme is offered to students who have completed $2\frac{2}{3}$ academic years of medical school. There were no regulations requiring the students' return to rural areas after completion of training. Of the 163 students who have completed the programme, 43 have continued in medical school and another 27 are in residency training programmes. Primary care residencies have been chosen by 68; another 31 have completed their medical education and are in rural practice. Of the 22 practising in Minnesota, 21 have returned to rural communities.

664. NYS, H. De toegang tot de medische arbeidsmarkt een juridische probleemverkenning en -afbakening. **[Access to the medical labour market in Belgium: the legal situation.]** *Acta Hospitalia*, Leuven, 1977, vol. 17, no. 2, pp. 91-123.

The legal aspects of the entry into the practice of medicine in Belgium are outlined. A distinction is drawn between 'direct' practice (setting up a new private practice, taking over an existing practice, or joining a general practitioner group) and 'indirect' practice (in a public or private hospital). In 'direct' practice there are few restrictions which affect the entry into practice and in both 'direct' and 'indirect' practice access to the 'medical labour market' is largely controlled by doctors themselves. The same applies in the Netherlands although here the Dutch government has introduced a bill which would give health care authorities more influence over entry to medical practice. In Belgium a research project is looking into the whole question of the medical labour market.

665. BEGUN, J. W. **Refining physician manpower data.** *Medical Care*, Philadelphia, 1977, Sept., vol. 15, no. 9, pp. 780-786.

Many conclusions about trends in physician manpower are based on the American Medical Association's (AMA) Physician Masterfile. Comparisons of specialty and activity status of physician's overtime are hampered by changes in the AMA classification procedure in 1968 and growth in the 'not classified' category since 1970. A method of adjusting data on physician manpower, taking into account these changes, is presented. The adjustments suggest that movements in the total physician supply away from patient care and primary care practice are overstated by use of unadjusted AMA

data, and the percentage of physicians engaged in patient care has increased rather than decreased over the past decade.

666. ENGLEMAN, S. R. **The hospital medical career structure.** *Health Services Manpower Review*, Keele, 1977, Nov., vol. 3, no. 4, pp. 18-20.

This paper explores the underlying causes which in recent years have combined to frustrate attempts to implement a viable medical career structure in National Health Service hospitals. The principal cause appears to be the failure to restrain the rate of growth of junior hospital doctors as planned, largely because of the level of demand for their services. At the same time the target rate of growth in the consultant grade has not been met, for financial reasons in the last two years, but also because of failure to fill posts in some regions and some resistance to additional posts unless provision was also made for additional junior posts. In general, the question is not only one of balancing numbers in junior and senior grades, but also of satisfying service requirements while at the same time providing a reasonable career structure.

667. MCLACHLAN, G., editor. **Medical education and medical care: a Scottish-American symposium arranged by the Nuffield Provincial Hospitals Trust and the Josiah Macy Jr. Foundation to commemorate the 250th anniversary of the founding of the University of Edinburgh Medical School and the Bicentennial of the declaration of Independence and the founding of the United States of America.** Oxford University Press for the Nuffield Provincial Hospitals Trust, 1977, xiv, 215pp. £6.00

This is a collection of essays commissioned for the Macy/Nuffield symposium held in Edinburgh in September 1976 in joint celebration of the founding of the Edinburgh Medical School and of the American bicentenary. The position of influence in the history of medicine, science and general practice, held by Edinburgh is discussed, together with the profound influence which Edinburgh graduates have had upon early medical practice and education in the United States. Other themes considered include: the position of the supplier of medical care; the influence of public policies and government; the need for pressures for equity of access and service; and the seeking through better organization for economies against an ever-rising bill for personal services.

668. SPENCE, A. A. and others. **Occupational hazards for operating room-based physicians.** *Journal of the American Medical Association*, Chicago, 1977, Aug. 29, vol. 238, no. 9, pp. 955-959.

Comparative analysis of data from three large retrospective surveys in the United States and United Kingdom reaffirms an increased incidence of spontaneous abortion among female physicians working in operating theatres. The live-born children of female physicians exposed in operating theatres also had substantially more congenital abnormalities. Male anaesthetists, compared with non-anaesthetist physicians, had an increased incidence of hepatic disease; there was also an increased frequency of congenital abnormality in their children. The incidence of spontaneous abortion in wives of male anaesthetists and in the rate of cancer among exposed male anaesthetists was similar to controls. Despite differences in survey methods and analysis, there was remarkable agreement in conclusions to be drawn from the independent studies.

NURSING STAFF

See also Abstract Nos. 739, 749, 750, 764, 787

669. GRYPDONCK, M., RODENBACH, M. Th. and WINDEY, T. Het model integrerende verpleegkunde: voorstel tot heroriëntering. **[Integrated nursing: model for reorientation.]** *Acta Hospitalia*, Leuven, 1977, vol. 17, no. 2, pp. 124-150.

The integrated nursing model described in this paper has three components. First it is concerned with the functioning of the nursing unit. Individual nurses are assigned responsibility for the total nursing care of a given number of patients. The group of nurses is co-ordinated by a leader. This frees the sister from some executive work and a ward secretary also relieves her of certain non-nursing duties. In addition, there is a 'co-ordinator' to see that new developments are put into practice and to act as a guide to staff implementing the model. The second component relates to communication between nurses: this involves the nursing plan (showing the tasks to be performed by the nurse for the patient), the nursing file (recording important information), and group discussions. The third component is concerned with making the best use of nursing hours: this includes the nursing roster and the patient profile, which fixes the workload on a ward so that staffing can be adjusted to it.

670. DELOUGHERY, G. L. **History and trends of professional nursing.** 8th edition. St. Louis, C. V. Mosby, 1977, viii, 277pp. £6.80

This edition is a revision of material prepared by G. J. Griffin and it outlines the development of nursing in the United States. Aspects considered include: the early history of nursing; American beginnings; contemporary nursing; and legal aspects of the nursing profession. Bibliographies are included after each section.

671. ZILM, G. N. and others. **Development and use of indicators in nursing research: proceedings of the 1975 National Conference on Nursing Research, November 3-5, 1975, Edmonton.** Edmonton, University of Alberta School of Nursing, 1975, vi, 220pp. $2.00

The objectives of the proceedings of the 1975 National Conference on Nursing Research are centred upon: (i) upgrading nurse researchers' abilities in relation to the development and use of indicators in nursing research; (ii) providing an opportunity for nurse researchers to discuss their research ideas and problems; and (iii) making information on 'indicators' as freely available as possible to nurse researchers, and health sciences centres. The papers are arranged in three sections, the first of which comprises three keynote addresses on social indicators, psychological indicators and physical indicators in nursing research. The second section of major papers and critiques includes subjects such as the measurement and testing of indicators, and the development of standards in nursing care. The final section of mini-papers covers studies of various aspects of nursing including the organization of research in Canada. A list of participants' names and a summary of research projects submitted for the Conference is included.

672. FRISS, L. **What do nurses do?** *Journal of Nursing Administration*, Wakefield Mass., 1977, Oct., vol. 7, no. 8, pp. 24-28.

In an attempt to answer the question 'What do nurses do?' four separate, inter-

related functions are discussed. The most basic role is seen to be that of assisting the patient—by participating in his treatment, whilst the second role is to act as co-ordinator—both within a group of patients and with other health professionals. Also nurses should intervene to affect the health status of patients, and finally they should inform other health care professionals of their insights into the health of their patients. These functions deal only with the role of the nurse in the direct patient care situation and the author points out that all nurses may not be capable of, or indeed wish to perform all four functions.

673. BALZANA, L. and others. L'infermiere unico polivalente. **[The multi-purpose nurse working alone.]** *Ospedale*, Torino, 1977, June/July, vol. 30, nos. 6/7, pp. 147-153.

In the light of the current debate on what kind of nurse is required to-day, the authors very briefly examine the health and social requirements of the population, trends in health and social services, and the functions, field of activity, and working conditions of nurses. They themselves favour a 'global' approach to care based on the concept of man as a psychological and physical being, and conclude that every nurse should be capable of providing the type of care required by each individual patient. Instead of having different kinds of training for, for example, paediatric and psychiatric nurses and health visitors, a three-year course should be mandatory for all future nurses and this would be followed by in-service training. The content of this training is briefly outlined.

674. LONG, A. and MERCER, G. **The turnover of labour in nursing.** Part Two. *Health Services Manpower Review*, Keele, 1977, Nov., vol. 3, no. 4, pp. 6-10.

The first part of this paper argued that, without reliable and valid personnel data, manpower planning policies are chimerical, and the discussion centred upon the determination of appropriate rates of recruitment, retention and departure. This part discusses two contrasting approaches to collecting information on why staff leave, using data from the Yorkshire study as illustrations of their value and limitations. The two approaches are: (i) exit (terminal) interviews and post-exit questionnaires; and (ii) scrutiny of potential recruits for particular attitudes or characteristics which, from previous research, are believed to predict length of service. The search for predictors of turnover, while revealing interesting details, was not very productive. The exit interview seems to offer a better yardstick of nursing views, given the current state of manpower research. The implications of this finding are discussed.

675. LEMIN, B. **First line nursing management.** Tunbridge Wells, Pitman Medical, 1977, v, 262pp. £3.95

This book, written for nurses who are new to management, or preparing for a management role, serves as an introduction to the subject and a hand-book of practical and personal skills used in management. Aspects covered include the background to management, its relation to people and classical management theory gained from research in industry. The importance of patients in management decisions is considered at all times.

676. ALLEN, M. **Evaluation of educational programmes in nursing.** Geneva, World Health Organization, 1977, 67pp. Sw.fr.12

This design for evaluating educational programmes has been developed in answer to the demand for guidance by nurses. The evaluation seeks to answer three questions: (i) whether the approach, operations and activities of the programme fulfils its purpose; (ii) what factors influence the programme to support or impede its development; and (iii) to what extent may the programme goals themselves be said to be valid? Aspects covered include criteria and design for evaluation, and programmes of evaluation. Topics included as separate sections are elaboration of the design in the community setting and a framework for analysis. A bibliography of 48 references is also included.

677. POPIEL, E. S., editor. **Nursing and the process of continuing education.** 2nd edition. Saint Louis, C. V. Mosby, 1977, xxii, 249pp. £6.20

Continuing education in nursing is in its infancy in the United States, but the rapid changes in the delivery of health care and public demand for more extended and improved health care, have made continuing education in nursing vital for every nurse. The various sections cover: what is continuing education; implementation of continuing education; who is involved; evaluation of continuing education schemes; and examples of continuing education schemes. An appendix and selected bibliography are included.

678. BUTLER, E. A. and HAY, B. J. **The passionate statistician: a computerised record of nursing sickness and absence. 2.** *Nursing Times*, London, 1977, Dec. 1, vol. 73, no. 48, occasional papers, pp. 153-156.

The first part of this paper [see *Hospital Abstracts*, Vol. 18, Abstract No. 497] described the development of a computer system for the analysis of nursing staff sickness/absence. This part outlines the system in use and presents some of the initial results. Some difficulties have been experienced in interpreting this information, which is not surprising as it is a new management tool. It is felt that the information will be particularly helpful in indicating: (i) when nurses are sick; (ii) where nurses are sick by ward or department; (iii) grade of nurses off sick; (iv) length of time nurses are off sick; (v) incidence of sickness among trained and untrained staff; and (vi) overall view of sickness throughout the district.

679. WILLIAMS, M. A. **Quantification of direct nursing care activities.** *Journal of Nursing Administration*, Wakefield, Mass., 1977, Oct., vol. 7, no. 8, pp. 15-18, 49-51.

A variety of methods are available for the quantative measurement of direct nursing care given to a patient, either within a unit or within different patient classification schemes. All the schemes have some disadvantages, as they are able to measure only a limited area of nursing care—activities carried out with the patient, that are behavioural in nature and observable. However, the resultant data can be used to determine staffing and budgetary needs. A selection of these methods are presented and the relevant advantages and disadvantages discussed.

680. BERGEN, B. van, HOLLANDS, L. and NIJHUIS, H. Een kwaliteitsprofiel van verpleegkundige zorg. **[A quality profile of nursing care.]** *Acta Hospitalia*, Leuven, 1977, vol. 17, no. 2, pp. 151-185.

The 'quality profile' for assessing the quality of nursing care which is described in this paper has been developed by the Eindhoven College of Technology Hospital Care Project and the Catholic College of Nursing, Nijmegen. A total of 139 'quality criteria' has been drawn up involving questions to nurses or patients and points are awarded for each. The total score for a ward is the number of points scored for all patients expressed as a percentage of the total number of points which could have been scored if all criteria had been fully met in the case of all patients. The system is compared with five methods of assessing the quality of nursing care developed in the United States. It is considered that the method described here compares favourably with the American ones and is a useful step towards better administration of nursing care.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See also Abstract No. 758

681. HASS, E. A. and SOLOMON, D. J. **Telling children about diagnostic radiology procedures.** *Radiology*, Easton, 1977, Aug., vol. 124, no. 2, p. 521.

At Children's Hospital Medical Center, Boston, Mass., brief, easily understood illustrated explanations of diagnostic radiology procedures are given to patients between the ages of three and 14. Those for out-patients are posted with the usual instructions for preparation; in-patients receive theirs a day or two before the examination. A sample of the explanations, which are on brightly coloured paper, is reproduced.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 645, 747

682. RAKICH, J. S., LONGEST, B. B. and O'DONOVAN, T. R. **Managing health care organizations.** Philadelphia & London, W. B. Saunders, 1977, xii, 350pp. £13.25

The aim of the book is to provide a framework to help health care managers work more effectively in health care organizations in the United States. The book follows a structured sequence throughout; part one describes the setting and the framework; part two describes the decision making process, the planning process and formulation of strategies; part three considers organizational design and structure; part four presents organizational dynamics—the activities important to getting things done by people; and part five focuses upon organizational controls and changes and how they can be accomplished.

683. MAILLARD, C., SIMON, J.-M. and CONTIS, J.-P. La fonction 'direction d'hôpital public'. **[The function of 'managing a public hospital'.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Nov., vol. 33, no. 386, pp. 42-48; summaries in English, German, Italian and Spanish, p. 48.

The authors develop the theme that the primary function of hospital management at

the present time consists in planning for the future. The administrator should develop medium and long-term objectives, i.e. specify the type of health facilities required for the future needs of the population, plan the capital and human investment needed, and co-ordinate the progressive implementation of these plans. The administrator also has to attend to the day-to-day management of the hospital. The authors stress the economic impact of the hospital as an enterprise. Present regulations and structures do not take account of the changes in management function and will have to be revised.

684. SERENI, A. Il management dell'ospedale nel quadro della riforma sanitaria (I). **[Hospital management in the context of health reform (I).]** *Tecnica & Metodologia Economale*, Firenze, 1977, Oct., vol. 16, no. 5, pp. 281-282, 284-288.

The existence of national and regional administrative and financial regulations, of the management committee, and the absence of control over the hospital medical staff, would suggest that, in one sense at least, hospital administrators cannot 'manage' Italian hospitals. The situation is further complicated by the reorganization of the health system and the introduction of the Local Health Units. The author suggests that the objectives or better still the functions of the hospital should be clearly defined for a start, and the relationship between the people who establish the objectives (basically a political choice) and those who supply them with the means of making a choice between objectives should also be defined. There is also a serious lack of organizational models.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 752, 755, 761, 769

685. HANAU, C. and ZUCCATELLI, G. L'economo e il sanitario di fronte al problema dell'efficienza ospedaliera. **[The finance officer and the health officer faced with the problem of hospital efficiency.]** *Tecnica & Metodologia Economale*, Firenze, 1977, Oct., vol. 16, no. 5, pp. 311-312, 314.

The formal organization of the Italian hospital structure with its two—administrative and medical—hierarchical pyramids has emphasized the gulf between these two worlds, and many hospital doctors continue to demand the most expensive equipment regardless of cost. The finance officer requires the doctor's co-operation in deciding whether, for example, the use of disposables is advisable, for without this co-operation his role is reduced to one of chasing or being chased by suppliers. The authors make a strong plea for greater co-operation.

686. ARNOLD. Leistungsdruck und Kostenbegrenzung im Krankenhaus. **[Pressure on services and cost limitation in the hospital.]** *Krankenhaus Umschau*, Kulmbach, 1977, Aug., vol. 46, no. 8, pp. 628-640.

The author first presents a detailed analysis of the most important factors which affect cost development in West German Hospitals. These are: staff; technology; legislation; the ability of doctors; the patient; and the community. A comprehensive cost benefit analysis could form a basis for political decisions on the health services. But significant benefits (for example, the 'humane' quality of the hospital) are not quantifiable. As for cost limitation, proposals which have been made for small piece-

meal savings seem irrelevant. For example, a 10 per cent reduction in drug costs would reduce hospital costs by only about 0.5 per cent. Reductions in staff complements would lead to unemployment with increases in social security payments: this would merely transfer costs from one area to another. Reduction in technical services could mean loss of medical efficiency although fuller use could often be made of expensive equipment. Laboratory lists are sometimes overdone. Costs resulting directly or indirectly from legislation are unavoidable although some inept provisions could be removed by amending the law. Medical students should be warned against blind reliance on technical diagnosis and made aware of the cost of the equipment they use. Patients too should be told of the financial consequences of the demands they make on doctors. But with the best will in the world, and however well people are informed, it will not be possible to limit costs fundamentally without drastic reductions in staff and services. West Germany has not yet come to this: DM40,000 million are spent each year on tobacco and alcohol and this fact must be borne in mind in any discussions on cost limits for hospitals.

RUNNING COSTS

See Abstract Nos. 700, 715

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract No. 689

687. FULLER, N. A. and PATERA, M. W. **Medicaid utilization of services in a prepaid group practice health plan.** *Medical Care*, Philadelphia, 1977, Sept., vol. 15, no. 9, pp. 705-737.

To provide medical services at lower costs without diminishing either quality or coverage, the District of Columbia enrolled approximately 1,000 Medicaid beneficiaries voluntarily in a prepaid group practice. Evaluation of the project over a three-year period indicated that for 834 individuals aged one to 64 enrolled in the practice: (i) ambulatory physician encounter rates decreased by 15 per cent; (ii) drug use was down 18 per cent; (iii) hospital admissions decreased by 30 per cent; (iv) hospital in-patient days declined by 32 per cent; and (v) the prepaid per capita costs were 37 per cent less than the fee-for-service capita costs of the Medicaid Universe. The study group patients were satisfied with the prepaid group practice and received better dental care. The voluntary dropout rate from the group practice was only 2.5 per cent and out-of-plan use was low; indicating good acceptance of the service.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 658, 678, 691, 692, 726, 754, 760, 762, 766, 776

688. CLÉMENT, J.-M. Informatique, hôpital et libertés. **[Informatics, hospitals and freedom.]** *Revue Hospitalière de France*, Paris, 1977, Dec., vol. 41, no. 306, pp. 977, 979-987.

The author reviews the development of computerized data processing in French hospitals and lists the various programs now used for management purposes and for

laboratories, blood transfusion centres, radiotherapy, cardiology, etc. Since the patient's name appears on most files, it is possible that personal information could reach unauthorised persons. The main risks are interconnection of the files, industrial disputes, and fires. The author examines these possibilities in the light of the draft law before the General Assembly (no. 25-16, 1976-1977 session) and suggests that responsibility for access to files should be shared in some way between the computer specialists and the administrators. He also discusses the proviso in the draft law which allows persons named in computer files to have access to the data relating to them to ensure that it is correct. Access to hospital files for patients would have to be indirect—through their general practitioners.

MEDICAL RECORDS

See also Abstract Nos. 688, 770

689. LYNCH, T. **Monitoring Ontario's health services.** *Dimensions in Health Service*, Toronto, 1977, Nov., vol. 54, no. 11, pp. 36-38.

This paper presents the findings of a study to review the existence of and need for monitoring procedures relative to the transfer of patients from the acute care hospital; it also refers to monitoring procedures currently being developed by the Ministry of Health in Ontario. The procedures covered include: (i) peer review; (ii) hospital accreditation; (iii) the Hospital Medical Records Institute, which analyses abstracts of all medical records from participating hospitals; and (iv) the Ontario Ambulance Services Information System. To provide a total information package of patient movement, record linkage between the various systems would have to be developed.

690. SANDLOW, L. J., BASHOOK, P. G. and HAMMETT, W. H. **Is the problem-oriented medical record really being used?** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 137-138, 140.

This paper is a preliminary report on the findings of a study of the use of problem-oriented medical records (POMR) begun in February 1975. Questionnaires sent to hospitals, medical and nursing schools and private practitioners sought information on use of, education in, acceptance of and expected expansion of POMR. Of more than 4,000 questionnaires distributed 2,615 (65 per cent) were returned completed. Among the main findings are: (i) 38 per cent of hospitals are using POMR and in another five, plans for using it are currently under way; (ii) 40 per cent have been using POMR for more than two years; (iii) most hospital physicians have learned POMR through teaching programmes of two or more sessions or by studying pertinent papers; (iv) the hospital physicians were moderately or strongly enthusiastic; (v) nurses in 22 per cent of the hospitals use POMR and 19 per cent have plans for introducing it; and (vi) the large majority of nurses were either moderately or strongly enthusiastic about POMR.

691. REGIONAL HEALTH RESOURCE CENTER and ILLINOIS UNIVERSITY. **First Illinois conference on medical information systems: proceedings of the conference held at the University of Illinois, Urbana, Illinois, October 17-18, 1974.** Pittsburgh, Penn., Instrument Society of America, 1976, iv, 199pp. £9.75

The first Illinois Conference on Medical Information Systems is the first of a

projected series of annual conferences sponsored jointly by the Regional Health Resource Center in Urbana and several divisions of the University of Illinois. The 22 papers presented cover many different aspects of medical information systems and their construction including the use of computer based systems for records and analysis.

692. CHEVALLIER, J., GRASSET, E. and MARTY, C. À l'hôpital Jean-Verdier: la gestion du dossier médical. **[Management of medical records at the Jean-Verdier Hospital, Paris.]** *Hôpital à Paris*, Paris, 1977, Nov./Dec., no. 42, pp. 503-510.

The 400-bed Jean-Verdier hospital opened in 1975 and its case records have been processed by computer from the outset. The authors briefly describe the layout of the records department, the storage area, the work of the seven members of staff, and the method used to extract records from the storage area each day, etc. Each patient has a permanent identification number which is recorded, together with details of name, sex, date of birth, date of first visit or admission, on the patient computer file which is updated each week. A computerized record summary is prepared when the patient is discharged. The way in which this is done is described in some detail; these summaries can be interrogated for epidemiological and research purposes. The article includes two photographs and reproductions of an identification card and a computerized record summary.

693. BERNSTEIN, A. H. **How accessible are medical records?** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 154, 156, 159.

This paper examines the extent to which medical records are available to parties in the United States contemplating litigation. It is largely a presentation of current state legislation and recent legal decisions.

HOSPITAL STATISTICS

694. Extraits du rapport d'activité de l'Assistance Publique en 1976: l'activité médicale; les dépenses de santé et le corps médical. **[Extracts from the report on the activities of the Assistance Publique, Paris in 1976: medical activities; health care costs; and medical staff.]** *Hôpital à Paris*, Paris, 1977, Nov./Dec., no. 42, pp. 539-563.

These extracts from the annual report of the *Assistance Publique* contain 25 tables and ten graphs which describe the pattern of medical activity and expenditure on health, and give the number of medical staff employed in 1976, and compare these data with those from the last six years. Although there were fewer short-stay beds in 1976 than at any time since 1970, the occupancy rate was the lowest ever; the overall number of admissions rose and the average length of stay in hospital fell. The activity of the ressuscitation and emergency units increased at the expense of the general medical units. Costs also increased—by 34.19 per cent between 1975 and 1976. The number of doctors almost doubled between 1965 and 1976, but the increase was less in 1975-1976 than in previous years. The number of medical students in hospitals in Paris fell slightly between 1975 and 1976, while the number of dentists employed in the four recently established centres for teaching, care and research continued to rise.

HOSPITAL ACCREDITATION AND SIMILAR SCHEMES

695. HYMAN, H. H. **Health regulation: Certificate of Need and 1122.** Germantown, Md., Aspen System Corporation, 1977, x, 185pp. $15.00

This book considers the passage of the National Health Planning and Resources Development Act of 1974 (PL 93-641) and the various changes that have taken place in the United States as a result of the 1122 amendments to the Social Security Act. The methods that can be used to develop institutional and regional plans and the advantages of each method are discussed. The areas considered include: the Certificate of Need (CON); effectiveness of health care capital expenditures; regulation of health care facilities and legal aspects of the regulation; health service and facility requirements; accountability; and the implications of the CON regulations.

696. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS. **Hospital survey profile: information copy.** Chicago, Joint Commission on Accreditation of Hospitals, 1977, [v], 168pp. $12.50

The Hospital Survey Profile (HSP) has been designed for hospitals in the United States to provide an easy method of obtaining an overall assessment of the current situation. By completing information profiles hospitals can define their current practices and procedures and use the HSP as a management tool for correcting any deficiencies revealed by the profile. The HSP can be a data bank of information about hospital methods. The Joint Commission has published the HSP in three formats—a blue official copy, a white hospital copy and a purple information copy which is on sale to the public.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 684, 693, 695, 722, 781

697. NICOLAI, M. Il sistema di controllo sugli enti ospedalieri e la loro configurazione giuridica (IV). **[The system of control of hospitals and their legal form (IV).]** *Tecnica & Metodologia Economale*, Firenze, 1977, Oct., vol. 16, no. 5, pp. 291-297.

A further extract from the author's thesis in which he examines the systems by which hospitals are controlled on the national and regional level in Italy. The regions have tended to separate the controlling agencies from the regions' political bodies and, as a result, they and the hospitals are in something of a vacuum. The problems that this situation produces for the hospital are examined in some detail.

FINANCE AND ACCOUNTING

FINANCE

See also Abstract No. 687

698. MELLET, H. **Capital stock and depreciation in hospital accounts.** *Hospital and Health Services Review*, London, 1977, Nov., vol. 73, no. 11, pp. 384-386.

The possible expansion of hospital accounts to include information on capital stocks

and depreciation is examined to determine whether the value of such information would justify the additional cost of providing it. Apart from its usefulness for distributing capital allocations and carrying out comparisons, the inclusion of the information in routine accounting reports should bring about an understanding and appreciation of the interaction between revenue and capital costs, which at the moment is not apparent. It is concluded that there is definitely a case to be made for including information on capital stocks and depreciation in accounts; the accuracy of this information will depend on the effort put into obtaining it. The aim is to balance this effort against the value of the extra information.

699. EGGER, A., KUNZE, M. and RUMPOLD, A. Wesen, Zweck und Aufbau der Kostenstellenrechnung in den Krankenanstalten. **[The nature, purpose and structure of cost-calculation in hospitals.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1977, Sept., vol. 18, no. 9, pp. 471-472, 474-476, 479-481.

This is a general description of cost accounting as it could be applied in Austrian hospitals. Terms are defined and the different types of bookkeeping and accounting described. Normal commercial accounting systems have to be adapted and extended if they are to meet the requirements of cost accounting in hospitals.

700. MUDARRI, S. P. and DENOBLE, R. A. **Better methods to determine true costs of hospital care.** *Management Controls*, New York, 1977, Sept./Oct., vol. 24, no. 5, pp. 28-30.

This paper describes the methods now commonly used by hospitals to determine what are euphemistically called 'true costs'. It then proposes for consideration two alternative methods of measuring the costs of providing services to patients: (i) establishment of an interdepartmental charge mechanism that provides for computation of a standard charge per unit of service rendered by each department, and the inclusion of anticipated interdepartmental charges in the records of each department; and (ii) generating revenue for all departments, by charging patients directly for services rendered by certain support service departments. It is believed that either of these alternatives would give hospital managers a clearer picture of their problems and would help to promote efficiency.

701. CATTAN, D. and others. Les coûts de la cirrhose alcoolique du foie en milieu hospitalier. **[Hospital costs of cirrhosis of the liver through alcoholism.]** *Hôpital à Paris*, Paris, 1977, Nov./Dec., no. 42, pp. 515-524.

A study was done in the 70-bed hepato-gastro-enterology unit of a large hospital in Paris over a three-year period with the object of demonstrating the high cost of treating alcoholic cirrhosis of the liver and the urgent need for prevention of this disease. The records of all patients in the unit were analysed by computer and it was shown that patients with alcoholic cirrhosis, i.e. patients whose known daily consumption of alcohol was more than one gram per kilogram body-weight, accounted for 7.34 per cent of the patients in the unit but for 16.27 per cent of the deaths. The alcoholic patients 'consumed' 10.69 per cent of endoscopy procedures, 12.45 per cent of radiological procedures, 17.84 per cent of laboratory procedures, and 30.67 per cent of blood transfusions. The cost per alcoholic patient was 15,337 francs in 1975. These results are presented in detail in 11 tables.

702. HUANG, L.-F. **Controlling inflation of Medicare physicians' fees.** *Policy Analysis*, Berkeley, 1977, vol. 3, no. 3, pp. 325-339.

The stringency with which Medicare carriers screen 'customary, prevailing and reasonable charge' (CPR) inhibits significantly the inflation of Medicare physicians' fees. The study reveals that the adoption of relative value scales or fixed fee scales has a major retarding impact on fee growth. The more frequently the CPR are updated, the greater the inflationary effect. In determining CPR both recognition of the speciality and the use of physicians' charges to both Medicare and non-Medicare patients as the data base, tend to slow down the rise of Medicare physicians' fees.

703. FOX, M. S. and MARKS, A. E. **New charge system reduces losses for patient-billed items.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 105-106, 108.

Lee Memorial Hospital, Fort Myers, Fla., has developed and implemented a new charge system that has reduced lost charges for patient-billed items. A study of 22 central service items commonly used by patients indicated that unaccounted-for items and charges represented as much as $100,000 per year in lost revenue. The new system uses dual-sticker labels on all chargeable items. The top sticker is transfered by the nurse to a patient identification card in a Kardex file when the item is used by a patient. The labels carry a code number indicating department or nursing unit and the chargeable item. Each day a central service technician checks the Kardex files, removing the cards with labels attached and preparing and inserting new ones. From an initial 92 items, the system has been expanded to 214 including rental equipment and intravenous solutions.

704. FRIEDMAN, E. **Medicaid: uncertain harvest.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 77-83.

This last paper in a series on Medicaid first examines some of the problems arising from aspects built into the programme at the time it was enacted. These include: the direct link between the programme and the welfare structure in the United States; the ever-expanding number of regulatory agencies, regulations, etc; the tangle of paperwork and bureaucracy; and some specific provisions of the law. It goes on to raise a number of questions regarding the present structure. Suggested solutions include: self-policing by providers; patient education; and patient involvement.

705. WELLS, R. H. C. **Health Maintenance Organisations and their feasibility in Australia.** *Australian Hospital*, Prahran, 1977, Oct., no. 13, pp. 8-9, 12; Nov., no. 14, pp. 9-10.

Both the Federal Government and Opposition would like to see Health Maintenance Organizations (HMO's) develop in Australia. HMO's would guarantee a full range of health care services in return for pre-paid fees and would offer the best possibility of controlling rising health service costs. HMO's have not so far been established because: (i) people do not realize the need for an alternative to existing schemes; (ii) the Government might lose votes; and (iii) the Australian Medical Association is opposed to the scheme. The author considers that Australia could tolerate a 60 per cent reduction in occupied bed days in hospitals and that savings could be made on drugs. A reduction in health costs would allow HMO's to provide: (i) low membership rates;

(ii) adequate returns on investment; and (iii) effective incentives to general and specialist practitioners, including individual and group bonuses and promotion prospects. The operation of the bonus scheme for general practitioners is described in detail. It would prevent unnecessary referrals and consultations and doctors could expect a better overall remuneration from belonging to a HMO. Group bonuses would benefit specialists such as pathologists and radiologists. HMO's would have to be established by government legislation and be financed by a scheme of Federal and State government subsidies.

HOSPITAL ACCOUNTING

See also Abstract No. 703

706. MANZANO, A. J., GRANT, P. and ERICKSON, N. **New accounting technique takes replacement costs into account.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 73-76.

Recently, the United States Securities and Exchange Commission issued Accounting Series Release (ASR) 190, which requires the use of replacement cost accounting for registered companies with assets of $100 million and over. After an in-depth study of ASR190, the usefulness of the replacement cost concept for hospital accounting and reporting was tested by the authors. Five years (1972-76) of statistics were gathered from three hospitals constructed in the 1960s with 150 , 300- and 500-beds. The data covered the four major asset categories (land improvements, buildings, fixed equipment and major movable equipment) and included historical cost, price level adjusted cost and replacement cost for each category. The results are presented in four tables and discussed. Replacement cost accounting emerges as a technique that could be very useful in hospitals in communicating a more accurate reflection of their financial situation to the users of the statements.

SUPPLIES AND STORES

SUPPLIES

707. KUTILEK, R. J., CALAMARI, F. A. and RHODER, J. F. **Materials management: an inexpensive model for a materials management system.** *Hospital Topics*, Chicago, 1977, Sept./Oct., vol. 55, no. 5, pp. 42-45.

Dissatisfaction with a centralized system of materials management at the Bronx Municipal Hospital Center, New York, led to the adoption of a trial project to decentralize certain areas of supply to departmental control. The Director of Pharmacy Services, the Director of Central Sterile Supply and the Director of Food Services all took over the materials management function of their departments, the Director of Pharmacy Services assuming the purchasing function as well. The new system required six to seven additional non-professional staff in each department. The areas of household supplies, chargeback and receiving remained the responsibility of the materials manager. The new plan used staff resources more efficiently, reduced costs significantly and increased use control.

708. LeGwin, L. C. **Waste containment committees can work.** *Southern Hospitals*, Greenville, 1977, Sept./Oct., vol. 45, no. 5, pp. 10-11.

A Waste Containment Committee was established at New Hanover Memorial Hospital, Wilmington, N.C., to: (i) educate employees in the need to conserve supplies; and (ii) generate ideas on how waste of supplies could be reduced. Reduction of waste was achieved by a number of projects, including: (i) the requisitioning of canned soft drinks and barium cups from a central source; and (ii) the education of staff in the care of linen; for example, by explaining the harmful effects of: (a) sticking adhesive tape to linen; and (b) mixing cellulose pads with items for the laundry. Attention was drawn to the general problem of unnecessary waste by two mobile displays which stated the use and cost of various items and provided a box for suggestions on how waste could be reduced.

PURCHASING

709. Guilhemsans, G. La politique des achats des établissements hospitaliers. **[Hospital purchasing policy.]** *Gestions Hospitalières*, Mantes, 1977, Nov., no. 170, pp. 807-816, 818-820.

The author believes that the purchasing officer must participate in the development of the hospital's purchasing policy and to do this he must be adequately trained and kept up-to-date with new developments. He should be able to obtain objective information as to the relative value of different types of equipment. The author discusses the advantages and disadvantages of centralized purchasing; he favours centralization on a regional as opposed to a national level, and recommends that computer files relating to products and suppliers should be maintained on a regional basis. The purchasing officer must also be capable of prices analysis, costs analysis, and value analysis, and must know the potentialities of the market and be able to use the various purchasing methods available—negotiation, group purchase, tenders—to the best advantage.

ECONOMIC USE OF SUPPLIES, DISPOSABLES

710. Grosso, E. Il monouso in ospedale. **[Disposables in the hospital.]** *Tecnica & Metodologia Economale*, Firenze, 1977, Oct., vol. 16, no. 5, pp. 299-302.

Although hospital infection can, in theory, be prevented by a well-trained staff in a clean environment, no effective prophylaxis has been found in practice. The author discusses the possibility of reducing the incidence of infection by using disposables and in the course of the discussion points out the problems encountered with modern methods of sterilisation. Since a wide range of disposables is now available and since the problems of storage before use and incineration after use can be overcome, it seems sensible to use more disposables.

711. Maggi, R. and Scarpini, F. Il monouso. **[Disposables, Part 3.]** *Tecnica Ospedaliera*, Milano, 1977, Sept., vol. 7, no. 9, pp. 68-77.

One of the main arguments against the use of disposables in the hospital, particularly plastic disposables, is that they cannot be disposed of. On the basis of recent work (there are 28 references) the authors show that plastic disposables can be: (i) dumped

in a refuse-tip after compression or pulverisation; (ii) composted with the help of thermophilic micro-organisms or fungi; (iii) incinerated, provided certain precautions are observed; or (iv) disposed of by pyrolysis. Their account is illustrated with four photographs or diagrams and two tables.

712. RYAN, P. **A rationale for single-patient items for isolation.** *Hospital Topics*, Chicago, 1977, Sept./Oct., vol. 55, no. 5, pp. 23-26.

To prevent cross-infection, various techniques for isolation have been specified by the United States National Center for Disease Control, but they are not always closely observed. The large number of single-use items have done much to promote safety and improve the effectiveness of isolation procedures. Single-use sheets are safer for isolation cases and avoid stains often found on re-usable sheets. The use of disposable sheets, gowns, towels and face cloths is economically justified when all processing and labour costs involved with re-usable linen are considered. The handling of contaminated linen presents a high risk, especially when the laundry service is outside the hospital.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

713. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and MEAT AND LIVESTOCK COMMISSION. **Cutting and preparing lamb and pork.** London, DHSS and MLC, 1977, 61pp. Enclosure to HN(78)2.

The Meat and Livestock Commission and Meat sub-committee have produced this volume on lamb and pork to complement the volume on beef produced in October 1974. The manual describes and illustrates the cutting and preparation of lamb and pork from carcase form to oven-ready steaks, cuts, and joints. The technical content of this volume has been reviewed and approved by the representatives of a number of the larger meat trade organizations operating hospital contracts. A glossary of terms and an appendix detailing the use of MLC pig carcase classification in carcase specification are included.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

714. BANISTER, R. **Hospital laundry and linen services.** *Hospital Development*, London, 1977, Nov./Dec., vol. 5, no. 6, pp. 21-22.

An effective laundry and linen service is essential for any hospital. The likely demand, combined with calculated costing, will determine whether the service should be provided on site, elsewhere in the local hospital service, or by an external contractor. Having decided that a laundry plant is viable, the optimum size can be estimated using a 'break-even' chart, based on both fixed and variable costs. Trained supervisors are needed to give job instruction and check standards of work. Plant lay-out and auto-

matic controls should allow for a smooth work flow, and equipment and procedures should be designed to protect employees from dermatitis and allergic complaints. The essential materials are soft water and a suitable cleansing agent. Laundry managers should keep in contact with their customers to check the quality of service provided. More automation and more on-site laundries are the probable trends for the future.

715. DURRWATCHER, R. **Documented proof—softened water cuts laundry costs.** *Hospital Topics*, Chicago, 1977, Sept./Oct., vol. 55, no. 5, p. 6.

Owing to the availability of both hard and soft water, the laundry manager at the Washington County Hospital, Hagerstown, Md., was able to make a comparison of the operating costs of both types of water. As a result of his findings, a water softener was installed, producing: (i) a reduction in washing costs; (ii) reduced linen replacement costs; (iii) a saving in water and chemical costs; and (iv) no increase in the number of laundry employees. Total costs have been reduced by one per cent per pound of linen processed.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

716. BRUUN, J. N. Renhold i sykehus. **[Hospital cleaning.]** *Sykehuset*, Oslo, 1977, vol. 40, no. 5, pp. 257-258.

The three methods of cleaning floors—conventional wet washing, wet mopping with an ordinary mop, and with disposable mops—will bring about a significant but temporary (one to two hours) reduction in numbers of bacteria on the floor in hospital rooms and corridors, with an accompanying increase in the airborne count. Conventional wet washing gives the worst results, and may even increase the amount of bacteria on the floor. Mopping gives better results, and damp mopping better still—provided mops are changed sufficiently frequently and are dried quickly after being washed out. Disposable mops overcome the risk of bacterial growth on the mop head, but their efficiency is slightly lower. All mops should be changed between each unit cleaned. Disinfectants should only be used on special indication. To be of any use, the infected area should be 'flooded' in disinfectant, which must be left to act for an hour before being removed. The bacterial count is higher on floors with fitted carpets than on conventional flooring, but where there is a low level of activity the aerial count is lower than above ordinary floors. At higher levels of activity the situation is reversed. Because of the danger of their acting as a reservoir for bacteria, fitted carpets are not recommended for patients' bedroom floors.

HYGIENE IN THE HOSPITAL

717. ASSOCIAZIONE NAZIONALE MEDICI DELLE DIREZIONI OSPEDALIERE. Atti della tavole rotonda sul tema attualità e prospettive dell'igiene ospedaliera. **[Proceedings of the Round Table on the present state and prospects of hospital hygiene.]** *Ospedale*, Torino, 1977, Aug./Sept., vol. 30, nos. 8/9, pp. 181-225. (Whole issue)

The proceedings of this one-day conference on hospital hygiene consisted of a

long paper on the present state of knowledge on hospital infection, three short papers: 'Isolation of high risk patients in a sterile environment', 'Technical aspects of hospital prefabrication', and 'Organization and methods in hospital hygiene', followed by eight brief interventions from other participants. In the longest paper Guzzanti and Bergami review the history of hospital infection and express the view that we are now in a neomicrobiological era. They recommend the following measures to reduce the risk of infection: (i) the reporting of all cases of infection to the appropriate authority; (ii) the isolation of patients, including reverse isolation, according to the degree of risk; (iii) the adoption of correct methods of cleaning, disinfection, asepsis, sterilization, and disinfestation; (iv) the correct use of antibiotics; (v) proper organization of hospital structures and technical services; and (vi) a suitable policy as regards staff training and supervision.

HOSPITAL INFECTIONS

718. TANNER, F. L'hôpital sous la menace des virus. **[Hospitals threatened by viruses.]** *Hospitalis*, Zürich, 1977, Nov., vol. 47, no. 11, pp. 592-594.

Protection in the hospital against the transmission of slow viruses, such as the virus implicated in Creutzfeldt-Jakobi disease, can be achieved if certain basic rules of hygiene are observed. These viruses are not totally inactivated by boiling or by ultraviolet rays. They are resistant to the action of aldehydes but sensitive to phenols and halogens under certain conditions. Dry heat sterilization is not effective, but sterilization by steam saturation—at 121°C for 20 minutes, at 134°C for seven minutes, or at 142°C for one to three minutes is satisfactory. Any material used parenterally in patients suffering from this disease must be sterilized before re-use. Protective clothing, masks, and gloves must be worn when a *post-mortem* is being carried out and electric saws should not be used. The table and *post-mortem* room must be disinfected after use with a fresh solution of five per cent sodium hypochlorite.

PREVENTION AND CONTROL

See also Abstract Nos. 712, 718

719. HNATKO, S. **A practiced guide to chemical disinfection.** *Dimensions in Health Service*, Toronto, 1977, Nov., vol. 54, no. 11, pp. 44-47, 50.

Many hospitals use as many as 20 different disinfectants; this has resulted in confusion, lack of understanding and poor technique. To avoid this, guidelines are presented which are based on laboratory studies and practical use over the last 15 years. They are summarized in two tables: giving properties of antimicrobial chemicals and currently practical chemical disinfectants. The latter shows for each disinfectant: equipment/area; preparation; area used; and disinfection treatment/comments.

DISPOSAL OF WASTE

See Abstract No. 708

SAFETY MEASURES

ACCIDENTS GENERALLY

See Abstract No. 759

ELECTRICAL ACCIDENTS

See Abstract No. 656

FIRES AND FIRE PREVENTION

720. GOMPEL, H. van. Le point de vue et l'intervention des corps de pompiers concernant la prévention d'incendie. **[Views and intervention of firemen concerning fire prevention.]** *Hospitalia*, Bruxelles, 1977, vol. 21, no. 3, pp. 134-137.

When a new hospital is being planned, the author suggests that the safety requirements should be clearly defined and advice obtained from experts. In the case of old buildings the need for structural alterations to meet fire regulations can be avoided if the fire risks are analysed and safety measures agreed with the local Fire Service. International statistics show (four tables) that nearly half of all hospital fires start in the heating or technical installations—oxygen, inflammable liquids, incinerators, etc., and another 43 per cent are caused by electrical installations and careless cigarette smokers.

721. LENOIR, J. La réglementation de la protection contre l'incendie et la panique dans les hôpitaux. **[Regulations on protection against fire and panic in hospitals.]** *Hospitalia*, Bruxelles, 1977, vol. 21, no. 3. pp. 142-146.

Belgian fire prevention regulations are based on three principles: (i) the need to reduce the risk of a fire starting or spreading; (ii) the safety of the occupants of a building in the event of fire; and (iii) access to the site of a fire for the rescue services. The author systematically examines the application of these principles to the regulations governing hospital construction and design: walls, roofing, stairs, lifts, evacuation routes, technical areas, warning systems, fire extinguisher system, and the observance of these regulations. Existing buildings can rarely be modified to meet the regulations in full but certain minimum standards can be met. He points out that preventive measures are useless if information for staff is inadequate, if the extinguishers are inaccessible, if evacuation routes are blocked and exits unusable, or if the fire brigade cannot reach the site of the fire easily.

722. KEERSMAECKER, J. de. La responsabilité juridique de la direction dans le cadre de la prévention des incendies dans les hôpitaux généraux et psychiatriques. **[Legal responsibilities of management in the prevention of fire in general and psychiatric hospitals.]** *Hospitalia*, Bruxelles, 1977, vol. 21, no. 3, pp. 138-141.

The author describes the hospital management's responsibility when a person is injured or killed as a result of fire in the hospital. Under Belgian law the penal code is invoked if an act or omission on the part of management constitutes an infraction of

the legal regulations. An action can be brought under the civil code if a cause and effect relationship can be established between an act or omission and injury or loss to an individual. The procedures and penalties in both cases are described here and concrete examples given.

723. ROLAND, C. Information, formation et sensibilisation du personnel. **[Informing, training and increasing the responsiveness of staff.]** *Hospitalia*, Bruxelles, 1977, vol. 21, no. 3, pp. 129-133.

To create a general awareness of fire hazards in the hospital the author suggests that each new member of staff be shown around the hospital and given a brochure containing the measures to be taken in the event of fire, the fire prevention standards to be observed, and a diagram of each floor with exits and emergency exits clearly marked. Regular staff meetings on fire risks should be held and the staff kept informed of new developments. Written instructions as to what to do in the event of fire should be prominently displayed. The hospital should have its own fire prevention and fire-fighting unit which should have both practical and theoretical training. In Belgian law, employers are required to inform their staff of the specific dangers involved in their employment, and to provide the safety committee and other interested parties with documentation consisting of the laws, regulations, and conventions relating to security and hygiene, and a list of dangerous substances used and their location.

PLANNING FOR MASS EMERGENCIES

See also Abstract No. 777

724. ZEISL, W. S. **Building an earthquake-proof hospital.** *Hospital Progress*, St. Louis, 1977, Oct., vol. 58, no. 10, pp. 48-49.

The new 209-bed Holy Cross Hospital, San Fernando, Calif., dedicated on 16 April 1977, replaces the 10-year old building permanently damaged by an earthquake on 9 February 1971. The new hospital conforms fully with the 1977 California Seismic Safety Code, which requires hospitals to be fully operational in an 8 + magnitude earthquake along the nearest approach of the San Andreas fault. A foundation was forged of a series of drilled cast-in-place reinforced concrete piles 30 feet in depth. Then the 2,000-ton ductile structural steel frame was constructed. Among other special earthquake resistant features are seismic joints between different sections of the building. Structurally, the hospital is six separate buildings connected by these seismic joints. The air-conditioning, fire protection and plumbing have also been designed to withstand earthquake stress. Very brief details are given of some features of the new hospital.

RADIATION HAZARDS

725. WORLD HEALTH ORGANIZATION. **Use of ionizing radiation and radionuclides on human beings for medical research, training and non-medical purposes: report of a WHO expert committee.** (Technical Report Series No. 611) Geneva, WHO, 1977, 39pp. Sw.fr.6

The aspects considered by this report on the use of ionizing radiation and radio-

nuclides on human beings include: biological effects of ionizing radiation and related risks; ethical aspects; methods for the surveillance of the irradiation of human subjects; the use of ionizing radiation in medical research; the use of ionizing radiation in education and training; and irradiation for non-clinical purposes. A list of recommendations by the World Health Organization is presented. Six appendices are also included covering: radiation quantities and units; estimates of radiation risks; types and categories of research involving irradiation of human subjects; selected clinical tests; and a statement by ICRP on security screening of airline passengers.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract Nos. 762, 782

726. BUTTS, M. S. and ASHFORD, J. R. **Hospital Activity Analysis: a source of information about serial hospital admissions.** *International Journal of Bio-Medical Computing*, Barking, 1977, Oct., vol. 8, no. 4, pp. 255-267.

A Hospital Activity Analysis (HAA) record is created in Britain for each in-patient spell for most acute specialties. The design of the system was not originally intended to facilitate the deliberate linking of successive admissions for the same patient. This paper describes how such linkage can be achieved by computer at little cost, taking account of possible errors in the recording of items of personal information. Applications of the procedure to give the clinician better access to information about previous hospital admissions and as a basis for monitoring the effectiveness of particular hospital based procedures are described.

WELFARE OF THE PATIENT

See also Abstract Nos. 681, 740, 756

727. KREMER, K. Humanitas im Krankenhaus. [*Humanitas* **in the hospital.**] *Österreichische Krankenhaus-Zeitung*, Wien, 1977, Sept., vol. 18, no. 9, pp. 495-496, 499.

The increasingly technical duties of nurses (e.g., in the intensive care unit and the operating theatre) are inevitably changing the image of the dedicated, ministering angel. During her training the nurse must be continuously reminded of the need for contact with patients and of the importance of listening to them. Increasing specialization and bureaucracy, more technology and shorter working hours mean that the patient has more and more staff members to deal with and that doctors have less time to talk to their patients. The patient, who has been torn from his normal environment and routines, has time on his hands to worry about his illness and his future. He needs reassurance and sympathy.

728. SCHOBER, Th. Humanität im Krankenhaus. [**Humanity in the hospital.**] *Österreichische Krankenhaus-Zeitung*, Wien, 1977, Sept., vol. 18, no. 9, pp. 485-486, 489-495.

The increasing use of technology, machines and highly qualified specialist staff in

hospitals increases the risk of the patient being treated as a 'case' or an 'illness' rather than as an individual. Doctors, nurses, hospital technicians and administrators need more training in psychology, human relationships, and the social needs of patients. Hospitals should be much more 'open'. The citizen should be told more about what his hospital is doing. There should be invitations to regular open days and doctors, nurses and administrators should take part in continuing dialogues. Much could be done to reduce regimentation of patients and the inflexibility of hospital routines.

729. WERTZEL, H. and others. **Analysis of patient-nurse interaction in hemodialysis units.** *Journal of Psychosomatic Research*, Oxford, 1977, vol. 21, no. 5, pp. 359-366.

A personality inventory, based on psychoanalytical principles (Giessen test), was used to analyse patient-nurse interaction on a haemodialysis unit. The study involved 28 patients and 13 nurses. Nurses as well as patients were asked to assess themselves and each other ('real profile'). In addition, they were asked to characterize an ideal self and an ideal nurse ('ideal profile'). Conclusions on patient-nurse interaction were based on the different profiles (real profile, nurse profile, ideal profile, profile of the standard population). The results are presented in six diagrams and discussed. Patients' views of themselves were different from those of the nurses, but they did not differ to any major extent on the personality profile of the ideal patient. The personality profiles of nurses, as seen by themselves, differed significantly from those of control individuals. Nurses saw themselves as being socially less resonant, dominant, depressive, retentive and lacking self-control. They thought the ideal nurse should be less aggressive, less depressive, socially more resonant and showing more self-control. The ideal nurse, as projected by the patients, had a personality profile that did not differ much from that of a normal individual.

730. SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY. **Nursing management of violent patients.** Croydon, South East Thames Regional Health Authority, 1977, 24pp. £0.20

This booklet has been written to accompany the film 'Guidelines to the Nursing Management of Violence' produced by the South East Thames Regional Health Authority. The booklet offers guidance to hospital and community nurses working with mentally ill, mentally handicapped or physically ill patients and illustrates, by means of photographs, practical suggestions for ways of dealing with violent incidents.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

731. FLEISHMAN, R. **Setting up a volunteer program for teenagers.** *Hospital Administration in Canada*, Don Mills, 1977, Nov., vol. 19, no. 11, pp. 30-31.

Based upon the experience of Mount Sinai Hospital, Toronto, the author outlines some of the requisites of a successful programme for teenage volunteers. Aspects covered include: ages of volunteers, selection, uniform, job descriptions, training, evaluation, and recognition.

TRANSPORT OF PATIENTS

See also Abstract Nos. 650, 778

732. BARNES, J. **The ambulance control function.** *Ambulance Journal*, Newport, I.O.W., 1977, Sept./Oct., vol. 5, no. 5, pp. 299-300.

Cranfield Institute of Technology is currently carrying out a study of the ambulance control function. Its terms of reference are: (i) to examine the organization of existing ambulance controls, and (ii) to consider whether present arrangements can be improved with a view to (iii) making recommendations on the design, layout, organization and staffing of controls, which might form the basis of central guidance to ambulance authorities. This preliminary paper summarizes present views on what constitutes good control practice, the methods being used to investigate some aspects of control, and the possibilities for future development of the work.

733. CHICKEN, E. **Health service communications.** *Ambulance Journal*, Newport, I.O.W., 1977, Sept./Oct., vol. 5, no. 5, pp. 295-297.

This paper first outlines the basic communications equipment currently used in the National Health Service. It then goes on to list the wider requirements of the major user of radio and allied communications equipment—the ambulance service. Finally the possibilities of a more effective use of existing facilities are discussed.

734. DAVIS, J. H. **Control of demand.** *Ambulance Journal*, Newport, I.O.W., 1977, Sept./Oct., vol. 5, no. 5, pp. 283-288.

The major factors whereby hospital arrangements inhibit the full use of available ambulance resources are: (i) 'bunching' of appointment times for consultative and treatment clinics; (ii) variation in day-to-day hospital-generated demand; and (iii) insidious and unplanned growth. Control of demand is an essential prerequisite for the provision of an efficient service to patients within the prescribed standards It is necessary to prevent insidious unplanned growth, and is vital in providing a firm baseline for future developments. A method is presented of examining the relationship between hospital appointments systems and non-emergency ambulance service for out-patients with a view to assessing the scope for improved co-ordination and the eventual control of demand. The method leads to the establishment of a daily quote figure for each hospital which, once agreed, forms the highest level to which demand for ambulance/out-patients can be generated. Extension of the procedure to other hospitals in the district will provide sufficient data for the publication of district profile quota figures.

735. LEE, K. **Integrated health care transport.** *Ambulance Journal*, Newport, I.O.W., 1977, Sept./Oct., vol. 5, no. 5, pp. 279-282.

This paper offers some speculations and conjectures as to the direction(s) in which the ambulance services could be moving and the challenges it might have to face in the years ahead. Recent trends which have or could have some significance for the range of duties and level of provision in the ambulance services are discussed. They are: (i) changes in demographic structures; (ii) changing concepts of need; (iii)

national and local priorities; and (iv) changes in resource assumptions. Those duties which are broadly 'health' are differentiated from those carried out for the social service and education departments of local authorities. It is contended, however, that all are concerned with the health of the individuals involved and that an integrated health care transport service is necessary. The case is then made for this being a tiered service, though there should be no single model for it.

736. RAITT, R. **Operational research—location of resources.** *Amulance Journal*, Newport, I.O.W., 1977, Sept./Oct., vol. 5, no. 5, pp. 293-294, 297.

The performance of an ambulance service depends to a considerable extent on the location of its stations. This paper discusses briefly the operational research studies carried out by the National Health Service Operational Research Group, the development of a mathematical model, the validity of this approach, and some of the general conclusions which can be drawn. These include: (i) increases in frequency of calls do not have nearly as much effect on the performance of services as increases in travel times of the same order; (ii) the most difficult part of the day is the evening rush-hour, approximately 1600 to 1800; (iii) a single tier system usually offers higher use of vehicles and crews; (iv) as many locations are required during the night as during the evening but with fewer crews; and (v) the safest generalization about ambulance services is that they are extremely varied.

737. WILBY, J. M. **Effective management.** *Ambulance Journal*, Newport, I.O.W., 1977, Sept./Oct., vol. 5, no. 5, pp. 289-292.

This paper attempts to identify those areas which appear more commonly to influence effective management of ambulance services. Those discussed are: its developing role; the organizational environment; the availability of potential chief officer material; management style; the management/rank structure; industrial relations; public relations; the management of change; and planning and national policy.

HOSPITAL CARE

See also Abstract Nos. 659, 679, 680, 705, 746, 753, 769, 779, 784, 788, 794

738. CHAGNON, M., AUDETTE, L. and TILQUIN, C. **Patient classification by care required.** *Dimensions in Health Service*, Toronto, 1977, Sept., vol. 54, no. 9, pp. 32-34, 36.

The main principles which should guide the development of a patient classification scheme are objectivity and normality. A specific nursing action characterized by its frequency and its scope should be the main factor to be considered in any scheme. The total average time needed for each activity must be measured, allowing for both direct and indirect care. The needs of a patient over 24 hours can then be estimated and patients classified on a basis of demand for care. The system can be adopted to quantify patient demand during each nursing shift. Time spent by nurses in activities unconnected with patients must also be calculated to achieve a total of nursing time spent on any one unit. Such a comprehensive classiffication scheme allows a patient to be classified quickly and, in normal conditions, can contribute to the maintenance of quality care.

739. AMBROSE, D. M. **Physicians and nurses rank of importance of nursing activities.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 115-116, 118.

A study was designed to find out and compare how nurses and physicians assess the priorities in nurses' patient care functions. The questionnaire used listed 50 statements describing nursing activities, which respondents were asked to rank in terms of importance. There were 150 usable responses (40 per cent) from the 378 nurses to whom the questionnaire was sent, and 97 (26 per cent) from the 373 physicians. The rankings showed a significant agreement only on the activities each profession considered to be most important; there was no agreement on intermediate and lower rankings. Neither the number of professional years of service nor the specialty of the physician or nurse explain these differences. Physicians ranked nurses' physiological activities higher than did the nurses. Nurses considered their involvement in the patients' self-care and discharge to be of importance second only to their medical activities, whereas the physicians considered these activities to be the least important. The implications of these findings are discussed.

740. MELROSE, J. **Audiocassettes help hospitals break language barriers to care.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 93-94, 96.

The six hospitals in Springfield, Mass., have co-operated with the University Year for Action Program (UYA) at the University of Massachusetts, Amherst, and volunteers from the university and the community, to produce a series of audiocassettes explaining certain hospital procedures in French, Italian, Polish, Portuguese and Spanish. Sufficient copies have been made available at nurses' stations, laboratories, admission offices and any other areas where a language barrier hinders communication between patients and staff. Steps in developing the programme by a UYA group were: selection of starting points; dictation; editing; interpretation (translation); field testing; cassette production; staff notification; monitoring use of cassettes; extension to other hospitals; and transfer of the programme to the individual hospitals. A list of the cassettes produced is given.

741. CUNNINGHAM, P. J., editor. **Nursery nursing.** 3rd edition. London, Faber and Faber, 1977, 214pp. £2.50

This guide to nursery nursing, now in its third edition, presents information on all aspects of nursery care. Topics covered include: development of the child; the principles of feeding and clothing; first aid; prevention of accidents; the importance of play; how the body works; prevention of infection; handicapped children; care of the sick child; and caring for other people's children. An appendix is included of training courses and careers for nursery nurses together with a select list of 27 books for further reading.

742. PEETERS, T. L'hospitalisation intégrée, une (r)évolution de l'hôpital. **[An integrated hospital system, a [r]evolution in hospitals.]** *Hospitalia*, Bruxelles, 1977, vol. 21, no. 3, pp. 108-117.

The author describes the introduction of a system of integrated care in a 161-bed private clinic whose policy has always been directed towards achieving maximum

participation and delegation of responsibility. After six months' planning, a pilot study was conducted in the surgical and maternity units. It was decided that it was impractical to introduce team working in the maternity unit, but this was feasible in the surgical unit. Different case record sheets had to be devised for maternity, gynaecology, and surgical patients. The attitude towards the re-organization of the unit's chief nursing officer was found to be crucial; if she felt her authority threatened, the new system failed. The benefits and disadvantages of the integrated care system are discussed in some detail. Tables are included which show the numbers of staff employed, and staff absences and resignations in each department before and after re-organization. Although difficulties were encountered, the results of the pilot study were positive and the system of integrated care is being extended to other units in the clinic.

743. HACKLEY, J. A. **Full-service hospice offers home, day, and inpatient care.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 84-87.

Hillhaven Hospital, Tucson, Ariz., is currently the only free-standing hospice in the United States to offer a comprehensive programme of care. Its range of services for terminal cancer patients includes home care, day care, 19 semi-private and one private rooms and a 12-month bereavement service for the family following the death of a patient. The hospice, developed and operated by an affiliate of an investor-owned nursing home group, shares a site with a skilled nursing facility and an apartment complex for the elderly. From the former it purchases catering, laundry and housekeeping services and also shares liability insurance. When a patient is referred to the programme, the hospice facilitator compiles all the relevant information and visits the patient and/or family. The application is then reviewed by the hospital interdisciplinary team. If hospice care is considered appropriate, an initial plan of care is formulated. Every effort is made to provide the necessary care in such a way that a dying patient may remain in his home or that of his family as long as possible, up to and including death if this is the patients' wish.

744. EGDAHL, R. H. and GERTMAN, P. M. **Quality assurance in health care.** Germantown, Md., Aspen Systems Corporation, 1976, xxi, 355pp. £19.75

This volume of essays is the product of a seminar on Quality Assurance in Hospitals held in November 1975 in Boston, conducted by the Boston University Program on Public Policy for Quality Health Care. A series of background papers were prepared for the seminar, each one analyzing a policy problem and suggesting possible action. Aspects considered include: the need for reorganizing present quality assurance methods; a review of quality assurance in the 20th century; the problems of federal policies and strategies to influence the quality of care; in-patient quality assurance schemes; an analysis of National Health Insurance issues; quality assessment information; hospital privileges and licensing; and financing methods and costs. Four bibliographies on the quality of medical care, peer review, medical audit and legal issues are also included.

745. GROSS, B. G. and KELLMAN, E. A. **Coping with two systems of review—is it possible?** *Hospital Topics*, Chicago, 1977, Sept./Oct., vol. 55, no. 5, pp. 12, 14, 16.

Hospitals in Rhode Island are: (i) moving towards PSRO (Professional Standards

Review Organization) Health Care Review status; (ii) attempting to comply with the standards of the 'Blue Cross protocol' for Blue Cross patients; and (iii) suggesting that Blue Cross share in the costs of the PSRO system. The PSRO scheme is favoured by the authors because it provides a national system of review which monitors each patient's case more closely than the 'protocol' system, sets down criteria for discharge and admission and revises the review process periodically. PSRO staff provide technical expertise in all areas of review, including assessing every aspect of a hospital's structure and then monitoring actual performance. The existence of two systems of review is possible, but not practical, and all constituent organizations in Rhode Island should support a single system of review for all hospital patients.

HOME CARE, AFTER-CARE

746. **Hospitals at home.** *Lancet*, London, 1977, Nov. 12, vol. ii, p. 1016.

'Hospital-at-home' schemes are working well in France and Geneva within the general framework of domiciliary care for the elderly. In France, all medical and paramedical care is given by specialist hospital staff under the overall responsibility of the family doctor, and in Paris in 1975, 5,433 patients benefited from the 'hospital-at-home' scheme. The success of the scheme depends on a careful selection of patients. The difficulties experienced include friction between the hospital and the family doctor and, more frequently, a shortage of home helps and other supportive staff who are invaluable in helping patients to retain their independence and maintain a rhythm of daily life.

SPECIAL DEPARTMENTS

WARDS

See also Abstract No. 789

747. HICKS, D. **The management of 120-bed clinical nursing units: an account of research carried out in the five years 1970-1974.** Winchester, Wessex Regional Health Authority, 1976, 2 vols.

This book is a report in two parts on the five year programme of research carried out in the Wessex Region during the years 1970-1974, directed towards establishing practical solutions to the problems of managing large nursing units. Aspects of management considered in Part 1 are: ward design, progressive patient care, pooling of beds, nursing workload, quality of care, and the information room. These aspects are applied in Part 2 to the current situation in the Wessex Region and the possible changes that can be made. A list of references is included.

748. MARZO, M. di and TORTORICI, G. Determinazione ottimizzata del numero di sale chirurgiche per ospedali generali. **[Optimized determination of the number of surgical wards for general hospitals.]** *Tecnica Ospedaliera*, Milano, 1977, Sept., vol. 7, no. 9, pp. 36-43.

The authors' method of determining the optimal number of operating theatres for a general hospital is based on an analysis of the number of operations performed,

the number of surgical beds, the number of beds in specialties linked to surgery, the average length of stay, the bed occupancy ratio, the number of staff, the time taken for an operation, the time elapsing between operations, the length of time the theatre is in use, and the number of surgeons involved in one operation. They applied their method to the existing hospitals in the Province of Bari and found that one hospital had more theatres than it required while the other 13 did not have enough.

OPERATING SUITES

749. FREEMAN, D. M. **Operating theatre suites staff workload comparisons.** *NATNews*, Matlock, 1977, Sept., vol. 14, no. 7, pp. 19-20, 22.

Comparing staff/work load levels in various theatres within a district or area is an important factor in determining priorities and effectively allocating limited resources. To compare work loads objectively a unit of measurement is required which is common to all surgical specialties. The key factors are: the total units of operating time (UOT) available; percentage of that available time used; manning level available each UOT; throughput of patients each UOT; and additional factors affecting each department. A method for estimating theatre staffing level and comparing work loads is presented in two tables.

ANAESTHESIA

750. RODDY, P. C. and HAMBLETON, R. **Supply, need and distribution of anesthesiologists and nurse anesthetists in the U.S., 1972 and 1980.** *Medical Care*, Philadelphia, 1977, Sept., vol. 15, no. 9, pp. 750-766.

This paper examines the relationship between problems in anaesthesia care delivery and the availability and use of trained anaesthesia staff. The 1972 and 1980 projected supply of anaesthetists and nurse anaesthetists is described and compared to the current and projected need for their services. Two estimates of need are developed based upon differing degrees to which anaesthesia teams can be used effectively, this being contingent upon the size of the hospital's surgical work load. While the need estimates developed for anaesthetists for 1972 and 1980 are fairly close in aggregate number to the actual and projected supply, the estimates for nurse anaesthetists fall far short of their projected 1972 and 1980 supply. The 1972 need estimates are then compared on a statewide basis to the actual supply and mix of anaesthesia staff to reveal a severe maldistribution which is quantified in terms of shortages and excesses of anaesthetists and nurse anaesthetists for each state.

PHARMACY

751. CHARLES, B. La pharmacie hospitalière. **[Hospital pharmacy.]** *Revue Hospitalière de France*, Paris, 1977, Dec., vol. 41, no. 306, pp. 1027, 1029-1036, 1039.

This is a summary of a report prepared by a working party consisting of five hospital pharmacists and two administrators. They first define the functions of the pharmacy

and of the pharmacist: the latter is both a manager and a medical technician. His role is to provide the patient with the safest and most effective product at minimum cost. The working party recommends that more hospitals should combine for the purpose of making bulk purchases of drugs; some products should be put out to tender. Large hospitals should have a central pharmacy in order to reduce the costs of supplies and storage. It also recommends that hospital therapy committees should produce a periodic brochure listing the drugs always in stock, expensive products, the daily costs of some drugs, and information on equivalent drugs. They also discuss dressings, disposables, staffing ratios, and the optimum size for a hospital pharmacy.

752. OLSEN, G. G. and GOODMAN, M. E. **The cost-benefit of clinical pharmacy in a general hospital.** *Australian Journal of Hospital Pharmacy*, Prahran, 1977, vol. 7, no. 3, pp. 102-107.

A study is reported of the cost-benefits accruing from the introduction of a restricted hospital pharmacopoeia. The method of establishing the pharmacopoeia is outlined. When a doctor wished to prescribe an item not routinely stocked by the hospital, the onus was on him to demonstrate to the clinical pharmacist or, in cases of dispute, the medical superintendent that the particular variation was essential for the patient's well-being. To be incorporated as a stock item, such a substance had to be approved by the hospital's drug committee. The results of the cost-benefit analysis are presented in five graphs and four tables. Using inter-hospital comparison, the regime has produced evidence of considerable savings. When the efficiency has been assessed within the hospital on its previous historical cost record, it has been shown that very significant savings have been achieved. To compensate for any change in therapeutic requirements which may have accounted for either of these variations, a 'basket analysis' has been performed which discloses that the service is again operating efficiently.

753. RUSSELL, M. E. and DINEL, B. A. **Performance appraisal for hospital pharmacists.** *Canadian Journal of Hospital Pharmacy*, Saskatoon, 1977, Sept./Oct., vol. 30, no. 5, pp. 137-139.

The objects and characteristics of performance appraisal are outlined, with particular reference to self-evaluation and peer review. Features of the performance appraisal technique used at University Hospital, London, Ont., include: (i) a structural appraisal form (reproduced as an appendix) using criteria which are directly related to the pharmacists' job description; (ii) use of a numerical rating scale; (iii) use of a combination of peer review, self-evaluation and supervisors' evaluations; and (iv) merit salary increases based upon performance. The procedures followed are outlined. The system has been used successfully for the past three years.

754. LIPMAN, A. G. and MADEUX, B. **Computer-based formulary service reduces costs, eliminates confusion.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 109-110, 112.

Following the reorganization and expansion of its department of pharmacy services in 1970, the 883-bed Yale-New Haven (Conn.) Medical Center developed its own formulary which was published in October 1971 in a pocket-size booklet and

implemented in November. Since then a new edition has been published annually in July; interim changes are announced in the pharmacy bulletin for medical and paramedical staff. In 1972 the hospital was awarded a grant by the Connecticut Regional Medical Program to establish and direct a clinical drug information service to Connecticut hospitals. One aspect of the regional service was to assist participating hospitals in the development of viable formulary systems. Following the development of a shared formulary data base, the system was computerized using an IBM System 3, model 10 computer at one of the participating hospitals. The procedures followed are outlined.

755. PLUMRIDGE, R. J. **A conceptual approach to cost-benefit analysis of drug distribution systems within hospitals.** *Australian Journal of Hospital Pharmacy*, Prahran, 1977, vol. 7, no. 3, pp. 86-90.

The steps necessary in planning a cost-benefit analysis are outlined in a conceptual context, with emphasis on its application in comparing differing methods of drug distribution. Six steps are identified: (i) the desirability of such a study; (ii) pinpointing objectives; (iii) identifying costs and benefits; (iv) measuring costs and benefits; (v) importance of time and certainty; and (vi) presentation of results. The meaning of cost-benefit analysis, the staff required for the project, and the political and administrative problems which occur are discussed.

756. SHAW, J. and others. **Comprehension of therapy by non-English speaking hospital patients.** *Medical Journal of Australia*, Glebe, 1977, Sept. 24, vol. 2, no. 13, pp. 423, 425-427.

A survey was made of 1,832 patients who attended the out-patients' pharmacy of the Royal Melbourne Hospital during one working week. Approximately 280 patients were identified as non-English speaking, and of these, 257 answered a series of questions asked by a pharmacist. An interpreter was needed to communicate with 73 of the 257, yet only 31 were known to require such help. Fifty-two of the 257 patients had a good knowledge of the function, dose and frequency of their drugs. Fifty-one patients did not know the function, and 13 of these did not know the dose or frequency either. Only 78 per cent of the patients understood special warnings on the drug containers. Difficulty in communication was the main reason for poor understanding of drug regimes. To improve this situation, more trained interpreters should be available in the hospital.

LABORATORIES

757. DHARAN, M. **Total quality control in the clinical laboratory.** St. Louis, C.V. Mosby, 1977, x, 242pp. £7.15

This aim of this book is to provide information on different aspects of achieving quality in analyses performed in clinical laboratories in the United States. The aspects covered include: errors in the clinical laboratory; normal law of error; mean and standard deviation; accuracy, precision and reliability; quality of materials; intra- and inter-laboratory quality control schemes; quality control in microbiology; departmental quality control; quality control of laboratory instruments and equipment;

comparison of procedures; determination of normal values; quality control of technicians; and requirements for laboratory accreditation and licensing. A series of six appendices are included covering legislation, licensing, inspection, personnel standards, and a list of manufacturers of quality control materials.

758. WORLD HEALTH ORGANIZATION. **World directory of schools for medical laboratory technicians and assistants.** Geneva, WHO, 1977, 568pp. Sw.fr.55

This Directory in English and French forms part of a series of world directories of institutions for the training of health staff. The aim of the World Health Organization in presenting this book is to provide health administrators, educators and students with information which will constitute a basis for efforts to improve the education and training of auxiliaries. The Directory is in two parts; the first considers the training of medical laboratory technicians and the second that of medical laboratory assistants. The information refers to the year 1973 and the entries list by country the institutions in which training is available, details of the courses, criteria for admission and the responsibilities of the medical laboratory technician or assistant after training. Three appendices are included providing supplementary information.

759. BROWN, P. M. and SOUTER, R. V. **Health and safety in hospital laboratories.** *Journal of the Society of Occupational Medicine*, Bristol, 1977, Oct., vol. 27, no. 4, pp. 148-150.

The Health and Safety at Work, etc. Act 1974 requires occupiers of premises not previously covered by legislation to take a closer look at their health and safety practice. One type of establishment concerned is the hospital laboratory. At the request of senior laboratory staff an employment medical adviser and a factory inspector carried out a joint inspection of hospital laboratories in the Hull area. The inspection revealed several deficiencies which would not be acceptable if the criteria and standards appertaining to factories were applied. The particular aspects giving rise to concern included: ventilation, cleanliness, illumination, storage of chemicals and highly flammable liquids, fire provision, and the safe operating of autoclaves, centrifuges and other mechanical appliances. In the most modern hospital in the group, lack of consideration of safety and health factors in architectural design has meant that major problems will arise in the implementation of measures to correct deficiencies. The special problem of the risk of infective hepatitis is also discussed.

760. ABSON, J., PRALL, A. and WOOTTON, I. D. P. **Data processing in pathology laboratories: the Phoenix system.** *Annals of Clinical Biochemistry*, London, 1977, Nov., vol. 14, no. 6, pp. 307-329.

The Phoenix system, as implemented at the Royal Postgraduate Medical School, London, uses a Computer Technology Modular One computer, a minicomputer with a 16-bit word length and runs under the manufacturer's MODUS 4 time-sharing executive. Programs are written in CORAL 66. This paper is in three parts which describe: (i) the overall design and the main facilities; (ii) the file structure and basic operations; and (iii) further programs, staff training, and system performance.

DIAGNOSTIC X-RAY DEPARTMENT

See Abstract No. 681

RADIOTHERAPY DEPARTMENT

761. AUFRÈRE, M. and MABILLE. L'aide à la gestion du service de radiologie. **[Management aid to the radiology department.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Nov., vol. 33, no. 386, pp. 67-72; summaries in English, German, Italian and Spanish, pp. 71-72.

The authors describe in considerable detail a management system for the radiology department which is linked to the hospital's main computer. A coded list of more than 400 procedures and a request form were designed. The data are processed for invoicing purposes, and the computer also provides an analysis of requests for radiological procedures by department, the activity of the radiology department under each heading, lists of patients examined, the procedures carried out, and the technical parameters. The description of the system is accompanied by a diagram and a flow chart.

762. SABLIÈRE, S. C. and GEST, J. **A patient assignment system in a department of radiotherapy.** *Medical Informatics*, London, 1977, March, vol. 2, no. 1, pp. 3-10.

More than 1,200 patients a year are treated in the radiotherapy department of the Centre René Huguenin, Saint Cloud, France. The department must be operated and patients allocated to the six radiotherapists so as to: (i) minimize delay between decision and starting treatment; (ii) smooth peak load; (iii) balance the load between therapists; (iv) assign patients to therapists according to their fields of interest; (v) keep a general flexibility; and (vi) enable the system to be run as a matter of routine by receptionists or secretaries. A systems approach has led the authors to design a two-level structure: a distribution pattern is set up at management level on an annual basis; every week, actual results are taken into account; the next patients are simulated and the receptionist is given a command that aims at the decided distribution. Three years' operation of the system have shown the value of its characteristics of: permanent knowledge of the distribution; flexibility; minimum involvement of the computer; and psychological impact.

REHABILITATION

See Abstract No. 784

PHYSIOTHERAPY DEPARTMENT

763. LEENDERS, J. J. Th., SCHOPPEN HAVER, J. J. H. and SWIERINGA, J. Onderzoek fysiotherapeutische dienst in verpleeghuizen voor somatisch zieken. **[An examination of the physiotherapy service in nursing homes for the physically ill.]** Utrecht, Nationaal Ziekenhuisinstituut, 1977, 63pp.

The first part of this report is an assessment of the existing state of physiotherapy services in nursing homes, and concerns staff structure, manning, duties, treatment, indirect functions and general and individual aims of the homes. The second part discusses desirable aims and deals with physiotherapy in general, its relations to nursing homes, the tasks and position of the service, its staff structure, approach to patients, forms of therapy, planning and organization. More central planning and task division are recommended to improve efficiency and avoid over-capacity, under-capacity and time wasting. The third part discusses how to achieve these aims and deals with staff

structure, time studies and norms for physiotherapy treatments and for functions of senior and auxiliary staff. In the fourth part an example, based on the above data and recommendations is worked out for a fictitious physiotherapy service. Long-term, short and very short-term planning are discussed and suggestions are made for a patient's treatment roster. Final recommendations are: uniform registration by all nursing homes and their physiotherapy service organization; a research study into relations between physiotherapy and medical data; and a separate investigation into the physiotherapy service in homes for psychologically disturbed elderly patients. The paper includes 10 tables, an example of a treatment planning chart and trainee guidelines.

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract Nos. 701, 729

764. SKALS, A. Adaptationsprocessens forløb med henblik på dialysepatienter. **[Progress of the adaptation process, with particular reference to the dialysis patient.]** *Sygeplejersken*, København, 1977, Sept. 21, no. 37, pp. 4-7.

The dialysis department sister's first task is to recruit and train a motivated, stable staff of nurses—preferably on a three-year initial contract (to keep turnover down). The nurse's task is to assist the patient to find a modus vivendi adapted to his disease: to listen, assess and explain. The process of adaptation runs through the five phases of: shock and disbelief; comprehension; restoration; acceptance; and idealization/resignation. The nurse's job is to guide the patient and his family through these stages to the phase of successful adaptation, in which the chronic patient is able to live with himself and others. The article is illustrated with three interior photographs of a dialysis unit. There are three references (one English).

INTENSIVE CARE UNITS

See also Abstract No. 794

765. SKJAEGGESTAD, Ø., LIPPESTAD, C. and SIVERTSSEN, E. **Medical intensive care units in Oslo: a comparison between the units.** *Journal of the Oslo City Hospitals*, Oslo, 1977, Oct., vol. 27, no. 10, pp. 121-127.

A survey of the medical intensive care units at Aker Hospital, Deaconess' Hospital and Ullevål Hospital, Oslo, revealed that 90 per cent of in-patients in the city with acute myocardial infarction were treated in one of the units. The units in all three hospitals had the same equipment and used a common data chart and procedure for diagnosis and treatment. The lapse of time between the attack and admission varied from one hospital to another, as did the percentage of those requiring resuscitation and the percentage leaving hospital alive. Those received at the Deaconess' Hospital tended to be less seriously ill and the mortality rate was therefore lower. Those admitted to Ullevål Hospital were more seriously ill and more resuscitations were carried out than at Aker Hospital, and the mortality rate was higher. No definite conclusions were drawn from the results of the survey, except the fact that the location of the medical intensive care unit adjacent to the admitting area, as at Aker Hospital, is probably preferable.

766. Microelaboratori nelle unità di cura intensiva. **[Micro-computers in intensive care units.]** *Tecnica Ospedaliera*, Milano, 1977, Sept., vol. 7, no. 9, pp. 80-83.

A brief description, with one diagram, of the installations in the Thoracic Centre at Erasmus University Academic Hospital in Rotterdam, where the condition of the patients in the surgical, coronary, and respiratory intensive care units is monitored by a system of bedside modules and LSI-11 mini-computers linked to a central PDPII-10 computer. The software employed is GNOME-11 (General-purpose Network Oriented Multi-user Executive). The patients' ECG, arterial pressure, right and left atrial pressure, fluid balance, cardiac output, and respiration can all be monitored.

767. **Cardiovascular monitoring.** *Medical Instrumentation*, Arlington, 1977, Sept./Oct., vol. 11, no. 5, pp. 264-301.

The papers in this symposium present current concepts on areas of cardiovascular monitoring carefully selected to provide a broad overview. Following an editorial there are papers on: cardiovascular monitoring in the medical intensive care unit; the Unibed patient monitoring system—a new approach for a new technology; cardiopulmonary monitoring in the respiratory intensive care unit, monitoring in the operating room—current techniques and future requirements; cardiovascular monitoring in the coronary care unit; monitoring electrocardiographic data in ambulatory patients; and automation of measurements and interventions in the systematic care of post-operative cardiac surgical patients.

768. HALE, M. and others. **Psychiatric complications in a surgical ICU.** *Critical Care Medicine*, Baltimore, 1977, July/Aug., vol. 5, no. 4, pp. 199-203.

A retrospective study of patients referred to the liaison psychiatrist for consultation was undertaken in the surgical intensive care unit at Yale-New Haven Hospital. From 1 January to 30 June 1975, 322 patients were admitted to the unit, over 50 per cent of them from the cardiothoracic surgery service. Seven per cent of the patients required psychiatric consultation. As a group they had more prolonged stays, more frequent requirements for mechanical ventilation, a higher incidence of cardiac arrest, and a higher mortality rate than the entire unit population. The psychiatrist was asked to evaluate multiple behavioural syndromes, some of which were irreversible concomitants of grave illnesses. However, with certain syndromes, psychiatric assistance greatly facilitated the resolution of problems that hampered pre- and post-operative management and the patient's eventual recovery.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract Nos. 756, 782

769. ROBERTS, S. D. **Improving primary care clinics' effectiveness through assessment.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 123-124, 126, 128, 130, 133-134.

The year-long ambulatory care clinics effectiveness systems studies (ACCESS)

project was carried out in the out-patient clinics of William N. Wishard Memorial Hospital, Indianapolis. Three fundamental strategies were used to collect information: (i) interviews and questionnaires to determine the attitudes of patients and staff; (ii) direct observation and time and motion studies of patient flow and staff activity; and (iii) compilation of historic information about the clinics. The study led to the identification and analysis of major problems in clinic operations, medical record availability, organizational complications and finance. Operational changes made as as result of the ACCESS studies centred around reducing patient waiting times and improving the efficiency of patient processing through improved scheduling. During and after the study, some of the clinics were restructured and reorganized. Some general conclusions are drawn on the managerial atmosphere needed for problem solving in a public hospital out-patient environment.

770. VORZIMER, J. J. **Coordinated ambulatory care: the POMR.** New York, Appleton-Century-Crofts, 1976, viii, 128pp. £6.00

During the late 1950s Beth Israel Hospital, New York, began an experiment designed to alter the patterns of long waiting lines in disease-oriented rather than patient-oriented clinics, and the history and development of the Department of Ambulatory Health Services are presented. The use of Problem Oriented Medical Records (POMR) to analyze procedures and medical capabilities allowed the hospital to transfer from an unstructured record keeping system to one which allowed comprehensive and consistently clear data entries. The impact of POMR on record keeping in the out-patient department, and its application to emergency department care, hospital services, nursing and ambulatory health services are discussed. Further aspects include audit in the ambulatory health service environment, and potentials of computerization.

CASUALTY AND ACCIDENT

771. BLUM, H. T. and WALKER, W. **The university hospital in regional categorization.** *Journal of the American College of Emergency Physicians*, Lansing, 1977, Sept., vol. 6, no. 9, pp. 422-424.

Categorization and regionalization of hospital emergency services will continue to evolve. Some of the problems are discussed with particular reference to the role of university hospitals. It is suggested that a workable plan for categorization would consist of: (i) a regional network for non-metropolitan areas with categories such as local, areawide, regional or special regional centre; (ii) metropolitan categorization based on types of patient injury and specific availability of appropriate resources, which may be substantially different at night compared with during the day; (iii) physicians and ambulance staff familiar with the guidelines for transport of the seriously ill and injured; (iv) categorization of emergency care for critical patients that does not preclude stabilization in one emergency department with subsequent transfer to another hospital for definitive care; (v) categorization determined by multidisciplinary groups; (vi) better data collecting mechanisms so that categorization and regionalization may be evaluated and modified; and (vii) evaluation efforts directed towards financial implications of hospital emergency service categorizations.

772. MULLNER, R. and GOLDBERG, J. **The Illinois trauma system: changes in patient survival patterns following vehicular injuries.** *Journal of the American College of Emergency Physicians*, Lansing, 1977, Sept., vol. 6, no. 9, pp. 393-396.

To assess the impact of the Illinois Trauma Program, samples of vehicular injuries and deaths for a two-year period after the implementation of the system were compared with those for the previous two-year period. Trauma centre hospitals showed a statistically significant decrease in mortality rates, while those not designated as trauma centres had no change in mortality rates. Decreases in mortality rates were statistically significant for week-ends and for patients between the ages of 45 and 64. The methodology used and the implications of the study are discussed.

773. CETTOUR BARON, G. Les services d'aide médicale urgente: III—Perspectives de l'aide médicale urgente. **[Emergency medical services: III. Future perspectives.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Dec., no. 387, pp. 70-78.

The policy of concentrating the treatment of emergency and accident cases in a few centres may to some extent be explained by the desire to use expensive equipment and facilities as fully as possible, and also by the fact that a doctor now generally accompanies the ambulance to the scene of an emergency, and he can decide on the spot which centre is most suitable for the patient. The author reviews recent economic studies which show that society as a whole benefits from prompt treatment of the injured, if only by reducing the number of days spent in hospital. He suggests that the development of more emergency departments could help break down the barriers between separate units within the hospital. More doctors would be required to run the service, and this could lead to an extension of full-time working for hospital doctors or part-time employment for doctors now in private practice.

774. ANDREINI, A. Il dipartimento ospedaliero. Part II. **[The hospital department Part II.]** *Tecnica Ospedaliera*, Milano, 1977, Sept., vol. 7, no. 9, pp. 20-35.

The author analyses the functions of the Admission and Emergency Department (AED) within the context of the Italian hospital system. Each general hospital has a Basic Emergency Centre, while a first-level AED serves a population of 100,000 and a second-level AED a population of 500,000. The AED is considered to be the most important department in the hospital since it provides immediate aid in any emergency and acts as an admissions filter at all times, since it has diagnostic facilities, multidisciplinary out-patient clinics, and intensive care and resuscitation units. The author suggests an organizational structure for a first-level AED, discusses the medical staff requirement, the features of the intensive care units, and legal and administrative aspects. He also presents a design for the layout of an AED.

775. GIBSON, G. **Measures of emergency ambulance effectiveness: unmet need and inappropriate use.** *Journal of the American College of Emergency Physicians*, Lansing, 1977, Sept., vol. 6, no. 9, pp. 389-392.

Two new measures of the appropriateness of ambulance use are suggested: (i) unmet need, defined as the proportion of emergency patients who clinically need ambulance transport but do not get it; and (ii) inappropriate use, defined as the

proportion of emergency patients receiving ambulance care who did not clinically need it. In a survey in Erie County, New York, unmet ambulance need was found to be 55 per cent and inappropriate use 30 per cent. The two measures were cross-tabulated with patient and visit characteristics to identify the determinants of unmet need and inappropriate use and to generate recommendations for system changes to reduce both types of ambulance ineffectiveness.

776. ROBERTS, J. M., FARRAR, J. A. and HARVEY, P. W. **The use of a computer system in the study of the attendance profile in a district hospital casualty department.** *Computers in Biology and Medicine*, Oxford, 1977, Oct., vol. 7, no. 4, pp. 291-299.

A one in seven sample of casualty attendances (2,447) at the Royal Lancaster Infirmary in 1968 proved difficult to code and process. On statistical advice, a five per cent sample of attendances (1,011 cases) in 1974 was studied. The casualty department system and the data collection function are outlined. The computer package used was the Statistical Programming for the Social Sciences (SPSS). It was used by medical staff, non-versed in computing techniques, to research into various social and functional changes that may have altered the pattern of attendances. Systems used by general practitioners did not noticeably change the profile of the casualty attendances of any type of patient, incidents dealt with, or treatments given. Other examples of the use of the data are listed.

777. CHRISTOPHER, P. J. and SELIG, M. **Medical aspects of the Granville rail disaster.** *Medical Journal of Australia*, Glebe, 1977, Sept. 17, vol. 2, no. 12, pp. 383-384, 386.

The Sydney Metropolitan Disaster Programme became operational within five minutes of the Granville Rail Disaster of January 1977. The disaster plan, developed ten years ago, outlines the responsibilities of all the emergency services and lists recommended medical equipment and drugs. An account is given of the casualties and conditions in this incident and the management of resuscitation, evacuation and transport procedures is described. The disaster plan worked well and highlighted certain factors needed to carry out such a programme: (i) an equitable distribution of patients to nearby hospitals; (ii) a medical team able to carry out resuscitation and other life-saving procedures in adverse conditions; (iii) adequate relief for rescue teams; and (iv) the establishment of a shelter at the accident site to facilitate co-ordination of the rescue work.

778. SCHUMAN, L. J., WOLFE, H. and SEPULVEDA, J. **Estimating demand for emergency transportation.** *Medical Care*, Philadelphia, 1977, Sept., vol. 15, no. 9, pp. 738-749.

This paper presents a method for estimating the demand for emergency transport using a data base obtained by sampling emergency room patient records. Correct and incorrect use are defined by matching levels of responses (mobile intensive care unit, basic emergency ambulance, transfer vehicle, non-emergency vehicle, and public or private transport, or no transport) to the level of severity (life-threatening, urgent, routine, transfer and dry run). From these definitions and data available from emergency facilities, demand and need are calculated. Multiple regression models are developed for estimating future demand. Data from a rural county in Western

Pennsylvania is then used with the models to develop predictive equations. In both cases, five significant variables explain over 90 per cent of the variation in number of calls for emergency transport.

779. ZORAB, J. S. M. and BASKETT, P. J. F. **Immediate Care.** London, W. B. Saunders, 1977, viii, 269pp.

This book presents information concerning many of the illnesses and injuries which need immediate care, and it emphasizes, in particular, the points of difference in the early management of the various conditions. Aspects considered include: basic care; specific measures in immediate care of trauma and immediate care of non-traumatic emergencies; and organization, training and equipment. A list of drugs which are known to differ in name between Britain and the United States is included.

DAY HOSPITALS

See Abstract Nos. 789, 791

INFECTIOUS DISEASES AND ISOLATION

See also Abstract No. 712

780. SCOTTISH HOME AND HEALTH DEPARTMENT. **In-patient accommodation for communicable diseases (Chairman: Professor E. M. McGirr).** Edinburgh, Scottish Home and Health Department, 1975, ii, 45pp.

This report of a Joint Sub-Committee on In-Patient Accommodation for Communicable Diseases considers the changing epidemiological pattern of communicable diseases in the United Kingdom. It also presents recommendations for future hospital provision for patients suffering from communicable diseases and infections, and also for the protection of patients suffering from immunosuppressive illnesses or under treatment which significantly reduces their immunity to infection. Aspects considered include: hospital accommodation; microbiology and epidemiology; in-patient accommodation; current use and future bed requirements; and teaching and training for nurses and doctors. A series of appendices are included presenting information on current use and bed requirements in tabular form.

CHILDREN

See also Abstract No. 741

781. HOLDER, A. R. **Legal issues in pediatrics and adolescent medicine.** London, 1977, xv, 350pp. £13.90

This book describes and elucidates for the paediatrician and the child psychiatrist the legal issues in the United States that bear upon the practice of medicine involving children and their families. The chapters cover a wide spectrum of issues and describe the law as it exists today and as it may evolve in the future. Topics considered cover:

legal issues at conception and during the prenatal period; amniocentesis genetic counselling and genetic screening; foetal research; the child and death; the minor's consent to treatment; the minor as a research subject or transplant donor; the paediatrician and the schools and the courts; the minor and the psychiatrist; and minors, contraception and abortion. Examples of cases are included together with a list of references.

782. COLLATZ, J., NATZSCHKA, J. and SCHWOON, D. Krankheiten, Einweisungshäufigkeit und Krankheitsverläufe bei auslandischen Kindern im Krankenhaus. **[Type of illness, frequency of referral and course of illness among children of foreign workers admitted to hospital.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1977, Dec., vol. 39, no. 12, pp. 746-758.

This paper presents a detailed analysis of the diagnoses, frequency of referral and the course of illness among the 8,504 German children and the 716 children of foreign workers (Turkish, Greek, Spanish, Italian and Yugoslav) admitted to a Hanover children's hospital in 1973. The results are set out in a graph and 10 statistical tables. It is shown that the foreign children (and Turkish children in particular) were admitted for in-patient treatment more frequently than German children. The diagnoses for the two groups differed; foreign children suffered more from infectious diseases, intestinal diseases and accidents than did the Germans. Referral of foreign children was often delayed, because a doctor was not consulted, until emergency admission was necessary. Language and other difficulties often make it impossible to obtain a proper anamnesis. The following recommendations are made to improve the lot of these foreign children: (i) more education of both parents and children to prevent street accidents to which foreign children are particularly liable; (ii) more facilities for the pre-school care of foreign children; (iii) foreign parents should get more guidance on nutrition and health matters and should be encouraged to seek medical help at an earlier stage; and (iv) there should be better facilities for the care of children outside the hospital or as out-patients. Foreign doctors and nurses should be recruited to help overcome language difficulties.

783. **Child life therapists help humanize hospitalization.** *Hospitals*, Chicago, 1977, Nov. 1, vol. 51, no. 21, pp. 14, 16, 20.

The 105-bed Doernbecher Memorial Hospital for Children, Portland, Oregon, has had a child life programme since July 1974; it is staffed by four salaried child life therapists. The main goal of the programme is to develop a one-to-one relationship between therapists and hospitalized children and their families. Referrals come from physicians, nurses and students, but the therapists are also able to work with a child without a formal referral. Since the child's most common medium of expression is play, the therapist uses play in order to understand what the child is thinking and feeling and to allow the child to express for himself. The therapists do not take over either parental or nursing roles, but supplement and enhance them. However, the distinction of functions between child life therapists and nurses is often difficult; the only solution is open dialogue and a sense of trust and teamwork. An important aspect of the programme is the in-service training programme and supervision provided by the department of child psychiatry.

784. CREER, T. L. and CHRISTIAN, W. P. **Chronically ill and handicapped children: their management and rehabilitation.** Champaign, Ill., Research Press, 1976, xv, 183pp. £5.95

This book presents the problems of chronically ill and handicapped children in the United States and how handicaps have affected attitudes. Aspects considered include goals and treatment models and various methods of strengthening, increasing, acquiring, maintaining and weakening behaviour. The role of the institution is considered and its effectiveness. A select list of references is included.

785. WORLD HEALTH ORGANIZATION. **Child mental health and psychosocial development: report of a WHO Expert Committee.** (Technical Report Series No. 613). Geneva, WHO, 1977, 71pp. Sw.fr.7

The WHO Expert Committee on Mental Health in their 17th report discuss child mental health and psychosocial development. The Committee reviewed available knowledge and the possibilities of applying this knowledge in health and social welfare, and also identified the extra information that might be necessary and the methods of obtaining it. Aspects considered included: the current situation, patterns for existing services and epidemiological and developmental features; possibilities for action; preventive measures; treatment measures and research implications and priorities; and recommendations made as a result of the study.

GERIATRICS AND LONG-STAY

See also Abstract No. 648

786. KEELE. UNIVERSITY DEPARTMENT OF ADULT EDUCATION and BETH JOHNSON FOUNDATION. **The quality of life of the elderly in residential homes and hospitals: a report of a seminar arranged by the Department of Adult Education, University of Keele and the Beth Johnson Foundation, at Keele from 25 to 27 March 1977.** Stoke on Trent, Beth Johnson Foundation in association with Department of Education, University of Keele, 1977, 91pp. £1.75

The main concerns of the seminar were to examine the need for educational activities in home and hospital situations and to analyze some of the problems faced by those working in residential homes and hospitals. Aspects considered in the six papers include: the personal social services and the care of the elderly with special reference to residential care; stimulation, activity and involvement in residential homes for the elderly; the quality of life in long-stay geriatric wards; art for the elderly hospital patient; the quality of life of the elderly in residential homes and hospitals; and teaching the elderly. The list of course participants is included as an appendix.

787. WORLD HEALTH ORGANIZATION. REGIONAL OFFICE FOR EUROPE. **Nursing aspects in the care of the elderly: report on a working group, West Berlin, 29 November-3 December 1976.** (ICP/HSD 010 ex ICP/SHS 042) Copenhagen, World Health Organization, Regional Office for Europe, 1977, 30pp.

This report has been prepared by the Regional Office for Europe of the World Health Organization to review the present situation with regard to nursing in the care of the elderly in several settings of the WHO European Region, to develop and

lay down guidelines for the training and education of nursing personnel and to recommend immediate and long-term strategies for applying the guidelines. Aspects considered include: the elderly; the need for nursing care; the team approach; and education of the nurse. Three appendices are included which consider the role of nursing in the care of the elderly in health, sickness and terminal care; trends in health protection of the elderly; and a list of participants in the Working Group.

788. HESS, P. A. and DAY, C. **Understanding the aging patient.** Bowie, Md., Robert J. Brady, 1977, xiv, 172pp. £7.15

The subject of geriatric nursing is presented holistically on the premise that social and psychic factors are intimately linked to physical disorders. The book is divided into three sections: section one considers the basic knowledge of normal ageing and its implications for nursing care; section two considers the common diseases of old age, with special attention to nursing care for communication and mental disorders; and section three considers restorative geriatric nursing, including planning for continuity of care. An appendix on the theories of ageing, and a select bibliography are included.

789. **NE Thames RHA: geriatric wards and day units.** *Hospital Development*, London, 1977, Nov./Dec., vol. 5, no. 6, pp. 26-27.

A standard plan was developed by the Regional Architect to the North East Thames Regional Health Authority for geriatric wards and day units, using brick and wood, shallow pitched roofs and brightly coloured furnishings. St. Michael's Geriatric Hospital at Enfield has a large day hospital with plans to add ward accommodation, which will make the geriatric unit as large as that at Rochford General District Hospital. Ward units have also been built at Thurrock, Whipps Cross and Harlow, and two are projected at Braintree and Chadwell Heath. The standard geriatric ward units are composed of four six-bedded bays and four single rooms, linked by a corridor to day-rooms which are used by in-patients and out-patients alike.

790. BARON, and others. Des maisons de santé et de cure médicale. **[Long-stay hospitals.]** *Revue Hospitalière de France*, Paris, 1977, Dec., vol. 41, no. 306, pp. 1009-1017, 1019-1022, 1024-1026.

The authors examine the legal basis, the construction and equipment, the operation, staffing, and costs of long-stay hospitals for the elderly in the public sector in France. Many are built from standardized industrialized units and are attractive and comfortable. Some are independent and others are built in the grounds of existing hospitals. From the point of view of design, the planning of kitchens, laundry, workshops, and offices is poor; the fire escapes should have been covered in, and the corridors should all have been fitted with handrails. These hospitals are intended for the elderly chronic sick who can no longer live an independent existence, but the authors stress the need to make maximum use of the rehabilitation and physiotherapy facilities provided, so that as many patients as possible can return to live in the community. There are three tables and two charts relating to costs and staffing.

CANCER

See Abstract No. 743

CARDIOLOGY

See Abstract No. 767

UROLOGY

See Abstract No. 764

SURGERY

See also Abstract Nos. 668, 748, 768, 795

791. WILSON, D. **Day care—a suitable case for development?** *General Practitioner*, London, 1977, Oct. 28, pp. 48-49.

Since the late 1950's surgeons have regarded day surgery as a practical consideration in reducing waiting lists. Between 1975 and 1976 the number of day surgery patients increased by 50,000. Patients must be carefully selected and a day surgery should be run as a separate unit of the hospital with its own operating theatre, assessment room, recovery room and resuscitation equipment. Responsibility for post-operative care may vary from area to area, but where day surgery schemes have been well planned, neither the general practitioner's workload nor the patient's recovery period have been increased. There is no significant difference in cost for day as against in-patient care for the National Health Service or for the patient and his family, but cost saving is an inducement for the private sector to increase its day care units.

MATERNITY

See also Abstract No. 796

792. TEW, M. **Obstetric hospitals and general-practitioner maternity units—the statistical record.** *Journal of the Royal College of General Practitioners*, London, 1977, Nov., vol. 27, no. 184, pp. 689-694.

The share of general-practitioner units in the provision of maternity services has increased since 1956, but their facilities have been used less intensively than those of consultant obstetric hospitals. Their foetal and neonatal rates have been consistently lower than in obstetric hospitals, a disparity which the higher proportion of births in hospital, recorded as being at above risk, is not nearly enough to explain. These facts should be important considerations in making provision for maternity services to meet future changes in the birthrate.

793. ELLIMAN, A. M. **A paediatrician's view of planned early transfer following childbirth.** *Midwife, Health Visitor and Community Nurse*, London, 1977, Nov., vol. 13, no. 11, pp. 352-354.

Provided there are no medical or social reasons against it, current practice favours sending mothers and babies home 24 hours after delivery, following a thorough examination of the baby. Indications against early transfer include: (i) small-for-date

babies; (ii) babies with an infection or feeding problems; and (iii) babies with certain congenital abnormalities. Problems such as jaundice which may develop after discharge can generally be dealt with without re-admission. Figures at the West Middlesex Hospital indicate that fewer than two per cent of babies discharged before 48 hours after birth require re-admission before the age of two weeks. However, early transfer to the home must be accompanied by an assurance that the general practitioner or midwife is able to bring the baby to hospital urgently if the need should arise.

794. STERN, L., FRIIS-HANSEN, B. and KILDEBERG, P. **Intensive care in the new born.** Lancaster, M.T.P. Press, 1976, [xii], 283pp. £19.50

During the past decade there have been extraordinary advances in the care of the infant-at-risk resulting from the increased knowledge gained from extensive technological advances. This volume presents some of the advances and considers the problems remaining in neonatology. Aspects covered include respiratory distress, dietary care, mineral and electrolyte metabolisms and necrotizing enterocolitis. Each of the 24 chapters contains illustrations and tables with extensive references. An author and subject index to the material are included.

OPHTHALMOLOGY

795. **Western Ophthalmic Hospital, London: theatre conversion scheme.** *Hospital Development*, London, 1977, Nov./Dec., vol. 5, no. 6, pp. 18-19.

Two new ophthalmic operating theatres have been created from one old single theatre in a re-building scheme at the Western Ophthalmic Hospital, London. The new theatre suite contains two anaesthetic rooms, a recovery area, a sterile store, disposal room, staff rest room and changing rooms, all within an area of 190 square metres. The conversion is described in detail. All the wiring and plumbing is new, the suite is fully air-conditioned and the theatres contain modern equipment, such as lasers.

PSYCHIATRY

See also Abstract Nos. 701, 730, 768, 785

796. BARDON, D. **A mother and baby unit in a psychiatric hospital.** *Nursing Mirror*, Sutton, 1977, Dec. 8, vol. 145, no. 23, pp. 30-33.

The existence of a mother and baby unit in a psychiatric hospital prevents babies being taken into care when their mothers suffer puerperal psychosis or other more long-term psychological illness. At Shenley Hospital, Middlesex, there were 633 admissions to the mother and baby unit between September 1959 and December 1976 and the average length of stay is about seven weeks. Just over half the mothers suffer from short-term depressive conditions. Nurses work with mothers and babies together and encourage mothers to take over in order to reduce the separation of mother and baby to a minimum. Manic and schizophrenic mothers maintain good contact with their babies, but nurses have to provide the stimuli for the inert baby of a severely depressed mother. Nurses have to build up a relationship with the mother to help her communicate with her baby.

797. RIESSMAN, C. K., RABKIN, J. G. and STRUENING, E. L. **Brief versus standard psychiatric hospitalization: a critical review of the literature.** *Community Mental Health Review*, New York, 1977, vol. 2, no. 2, pp. 1-10.

The paper aims to assess the published evidence available concerning the relative effectiveness of brief as against longer stays in hospital for the adult psychiatric patient. In general, it was found that there was no significant difference in functioning between the two groups, either on discharge or six months afterwards. Families of patients discharged after a short period experienced more difficulties at home, but these soon disappeared. There was no significant difference in re-admission rates between the two groups, but whether the groups can be differentiated by frequency or length of re-admission is not clear. Several studies revealed that post-hospital psychotherapy and drug therapy had been needed to produce social adjustment, but it is not clear whether one group required this more than the other. The authors note the methodological problems which ran through the investigations and gave rise to a need for caution in interpreting the results. These inconsistencies include: (i) variations in diagnostic and sampling methods; (ii) differences in drug therapy; and (iii) the effects of after-care schemes. However, the studies conducted to date show that a short hospital stay is feasible and economic, and a stay of over 60 days cannot often be justified.

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